

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR1. DECEASED NAME
(TYPE OR PRINT)

FIRST

MIDDLE

LAST

Timothy

Michael

Adkins

2b. DATE KNOWN OF DEATH
ESTIMATED
MONTH DAY YEAR
8 20 19812b HOUR
M
9:10 P.M.

3. SEX

Male

4. RACE

White

5. DATE OF BIRTH

May 4, 1981

6. AGE (IN YEARS)

3 1/2 months

IF UNDER 1 YR.

MONTHS DAYS HOURS MIN.

2c. DATE
PRONOUNCED
DEADMONTH DAY YEAR
8 20 19812d HOUR
P.M.7a. BIRTHPLACE (STATE OR
FOREIGN COUNTRY)

Towson

7b. CITIZEN OF WHAT COUNTRY?

U.S.A.

8. MARRIED ☐ NEVER MARRIED ☒
WIDOWED ☐ DIVORCED ☐

9. BALTIMORE CITY OR COUNTY OF DEATH

Carroll County

MD.

10. CITY OR TOWN OF DEATH

Westminster

11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION
(IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)

70 South Church St., Apt. #3

12a. USUAL OCCUPATION (TYPE OF WORK
FOR MOST OF WORKING LIFE)12b. KIND OF BUSINESS
OR INDUSTRY

USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)

13a. STATE
Maryland13b. COUNTY
Carroll13c. CITY OR TOWN
Westminster13d. INSIDE CITY LIMITS?
YES ☒ NO ☐13e. STREET ADDRESS
70 South Church St., Apt. #3

14. FATHER'S NAME

FIRST
Carroll

MIDDLE

Wayne

LAST

Adkins

15. MOTHER'S MAIDEN NAME

FIRST
June

MIDDLE

Elizabeth

LAST

Frock

16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(YES, NO, OR UNKNOWN)

No

16b. SOCIAL SECURITY NO.
(IF YES, GIVE WAR OR DATES)

17. INFORMANT

June E. Frock 70 South Church St., Apt. #3

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c):

PART I DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Sudden Infant Death Syndrome

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

7980

Conditions, if any, which
gave rise to immediate
cause (a) stating the under-
lying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b)
DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I a.

Urinary tract obstruction

19a. DATE OF OPERATION

19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?

20. AUTOPSY?

YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS

UNDERLYING ☐ OR
CONTRIBUTING ☐ CAUSE OF DEATH21b. TIME OF INJURY
HOUR A.M. MONTH DAY YEAR
P.M. 19

21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)

21d. INJURY OCCURRED

WHILE ☐ NOT WHILE ☐
AT WORK AT WORK21e. PLACE OF INJURY (AT HOME,
STREET, FACTORY, FARM, ETC.)21f. LOCATION
STREET CITY OR TOWN COUNTY STATE22a. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☐ Inquiry ☐ and in my opinion
death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐ACTUAL
SIGNATURE

Ann M. Dixon, M.D.

TITLE (SPECIFY)

M.D. Assistant

MEDICAL EXAMINER

DATE
SIGNED 8-21-81EXAMINER'S NAME
(TYPE OR PRINT)

ADDRESS

111 Penn Street

23a. BURIAL, CREMATION, REMOVAL
(SPECIFY)

Burial

23b. DATE

8-24-81

23c. NAME OF CEMETERY OR CREMATORY

Keysville Lutheran Cemetery

23d. LOCATION
CITY OR TOWN

Pahgetown

COUNTY

Carroll

STATE

Md.

24. FUNERAL DIRECTOR

NAME

D. L. Fletcher

Thomas D. Fletcher & Son F.H.

ADDRESS

254 East Main Street
Westminster, Md. 21157

25a. DATE REC'D. BY REGISTRAR

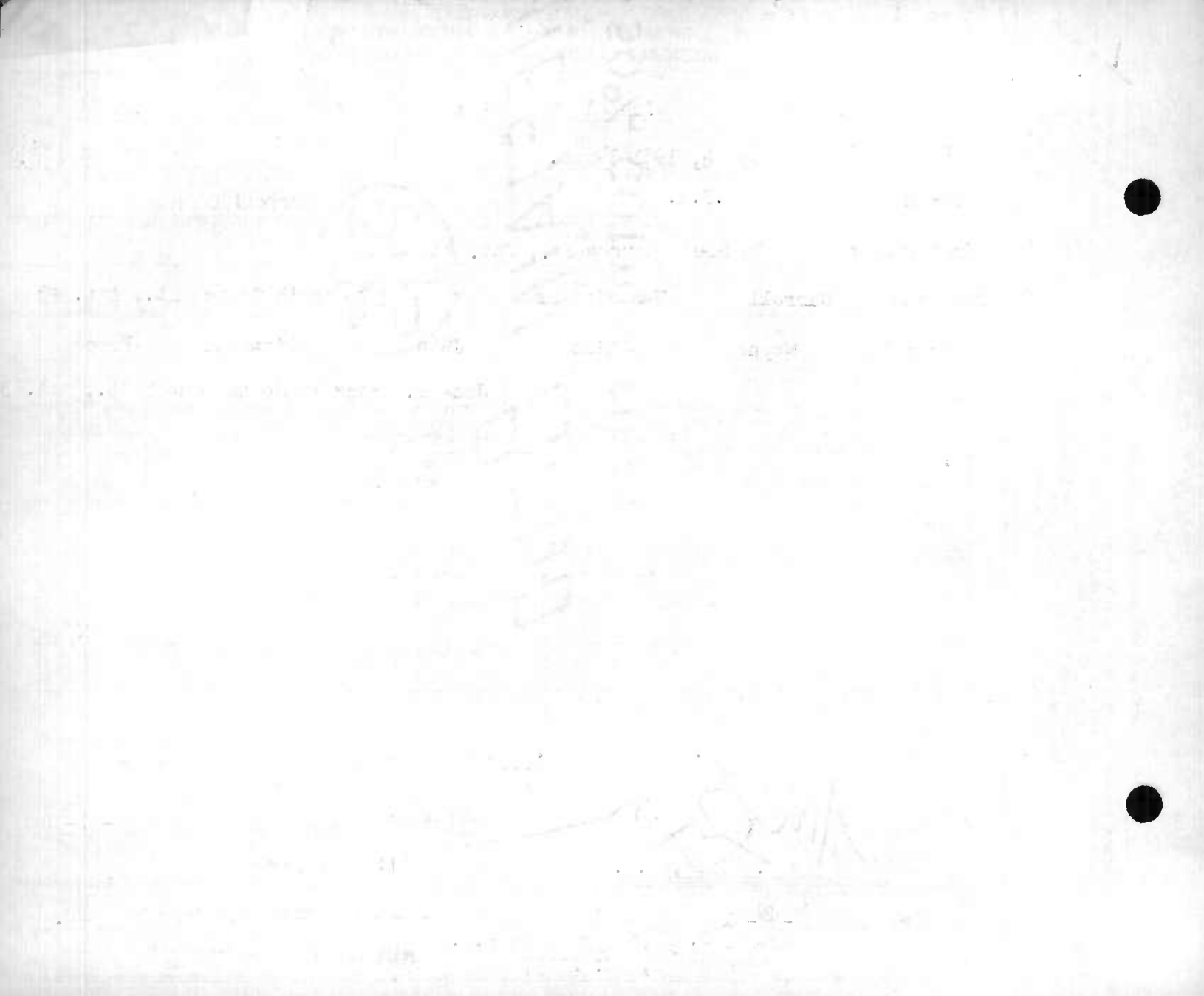
AUG 25 1981

25b. REGISTRAR'S SIGNATURE

James J. [Signature]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP



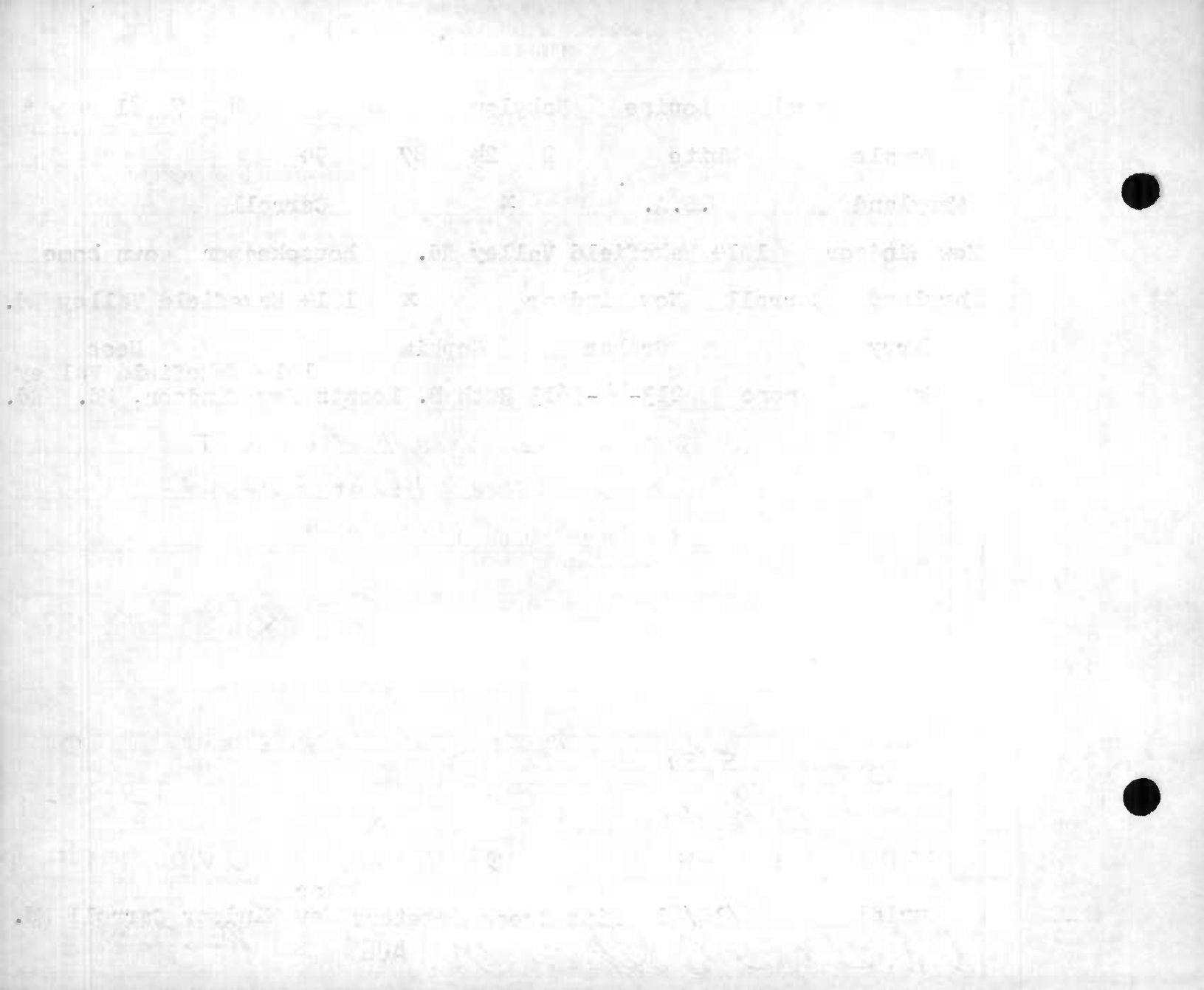
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) Sarah Louise Babylon					2a. DATE OF DEATH MONTH DAY YEAR 8 7 81		2b. HOUR 4:30 AM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 24 87		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD			
10. CITY OR TOWN OF DEATH New Windsor		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1014 Wakefield Valley Rd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) housekeeper		12b. KIND OF BUSINESS OR INDUSTRY own home	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 1014 Wakefield Valley Rd.	
14. FATHER'S NAME FIRST MIDDLE LAST Harry Graham				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sophia Hess					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT 1014 Wakefield Valley Rd. Ruth B. Koontz New Windsor, Md. Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CONGESTIVE HEART FAILURE (c) CORONARY DISEASE									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION 29		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 1978 , 19____, to PRESENT 19____, that (I) (we) lost saw the deceased alive on 5/81 19____ and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.									
22b. SIGNATURE John Lehigh MD								22c. DATE SIGNED 8/7/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN LEHIGH				22e. ADDRESS 104 N. MAIN ST. UNION BRIDGE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/10/81		23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery		23d. CITY OR TOWN COUNTY STATE New Windsor Carroll Md.			
24. FUNERAL DIRECTOR NAME D. D. Zerkow New Windsor, Md.				25a. DATE REC'D. BY REGISTRAR AUG 10 1981		25b. REGISTRAR'S SIGNATURE James J. [Signature]			

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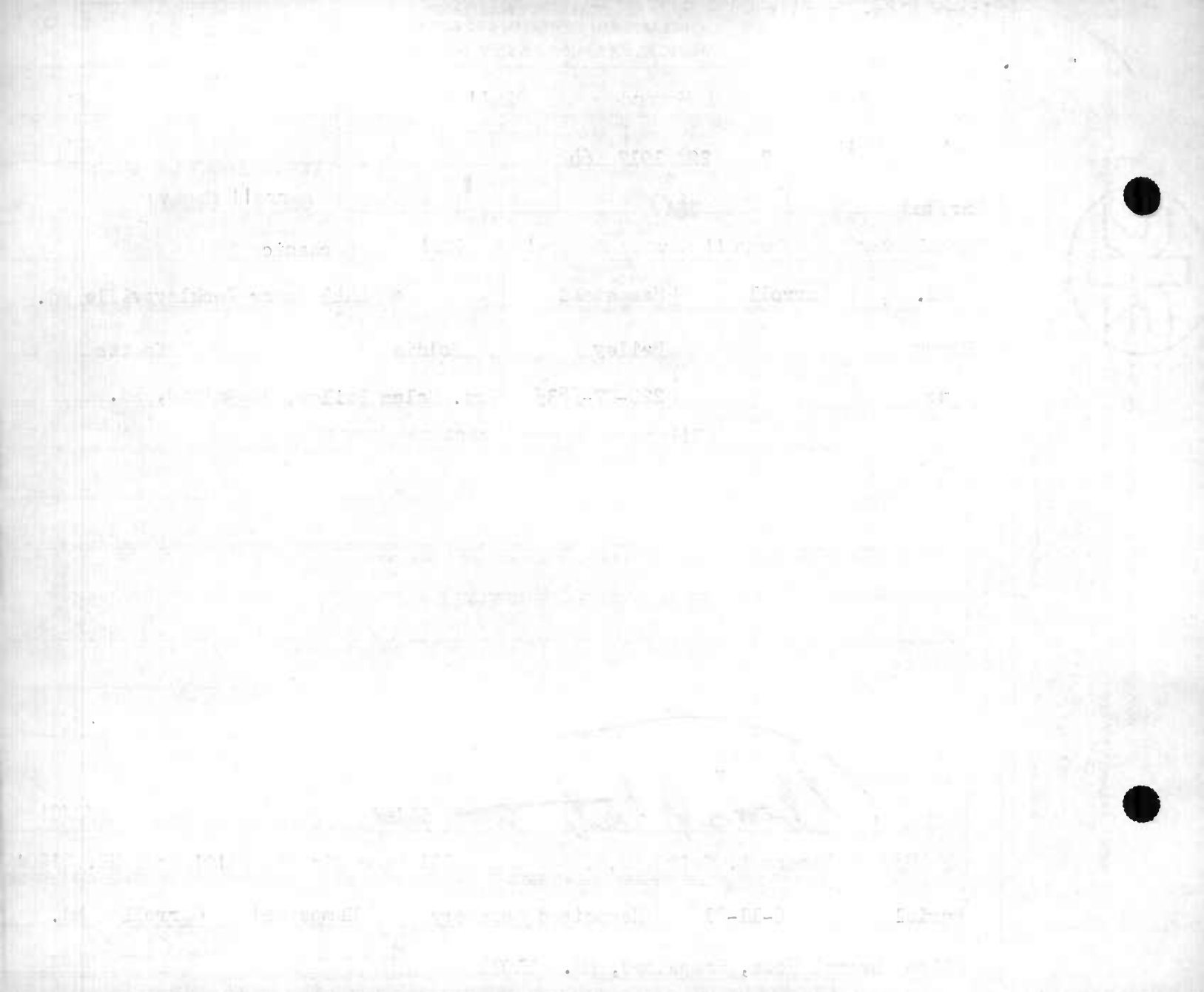


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 17 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Joshua Howard Bailey										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 8 DAY 8 YEAR 1981	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 7 DAY 22 YEAR 1917	6. AGE (IN YEARS) LAST BIRTHDAY 64 YRS.	IF UNDER 1 YR. MONTHS 6 DAYS 1	IF UNDER 24 HRS. HOURS 6 MIN. 1	2c. DATE PRONOUNCED DEAD MONTH 8 DAY 8 YEAR 1981		2d. HOUR M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Hampstead		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 4443 Upper Beckleysville Rd.			
14. FATHER'S NAME FIRST Harry MIDDLE Bailey LAST Bailey				15. MOTHER'S MAIDEN NAME FIRST Goldie MIDDLE Knotts LAST Knotts							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 220-07-5835		17. INFORMANT ADDRESS Mrs. Helen Bailey, Hampstead, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 2554 IMMEDIATE CAUSE (a) Bilateral adrenal cortical hemorrhage DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 8/8/81			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn Street, Baltimore, MD. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-11-81		23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery				23d. LOCATION CITY OR TOWN Hampstead COUNTY Carroll STATE Md.			
24. FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074 ADDRESS						25a. DATE REC'D. BY REGISTRAR AUG 14 1981		25b. REGISTRAR'S SIGNATURE Thomas D. Smith			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 30 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VRA 15 ME (5))
15M 2/80

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21237	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Luther Edward Bouds										2a. DATE KNOWN OF DEATH ESTIMATED 8 27 81	
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR June 1, 1903	6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 8 27 81		2b. HOUR			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.					
10. CITY OR TOWN OF DEATH Taneytown		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3663 Hyser Road,				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) W.S.S.C		12b. KIND OF BUSINESS Flt. Plant			
13a. STATE Md.		13b. COUNTY Carroll		13c. CITY OR TOWN Taneytown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3663 Hyser Road			
14. FATHER'S NAME FIRST MIDDLE LAST William Oliver Bouds				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alverta Clagett							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 579-26-6940		17. INFORMANT 8029 McKenstry Drive Robert L. Bouds Laurel, Md. 20707							
18. CAUSE OF DEATH (Enter only one cause preceding for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound the left chest</u> 9554 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Choke</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 530 P.M. 8 27 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Gunshot Wound							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Home		21f. LOCATION 3663 Hyser Rd Taneytown Carroll Md							
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion	
ACTUAL SIGNATURE <i>Richard A. Jones</i>				TITLE (SPECIFY) M.D. <i>Deputy</i>				MEDICAL EXAMINER DATE SIGNED 27 Aug 81			
EXAMINER'S NAME (TYPE OR PRINT) Richard A. Jones				ADDRESS 3663 Carroll County Courthouse							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 30, 81		23c. NAME OF CEMETERY OR CREMATORY Union Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Burtonsville Carroll Md.			
24. FUNERAL DIRECTOR Fleck Laurel Funeral Home, Inc 7601 Sandy Spring Rd. Laurel, Md. 20707				25a. DATE REC'D. BY REGISTRAR SEP 1 1981		25b. REGISTRAR'S SIGNATURE <i>James J. Harrison</i>					

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STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ALICE MAY BROWN			2a. DATE OF DEATH MONTH DAY YEAR AUG 27-1981		2b. HOUR 5:45 AM
3. SEX BE F	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR MARCH 5-1927		6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
10. CITY OR TOWN OF DEATH WESTMINSTER			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO HOSPITAL		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) DOMESTIC WORK			12b. KIND OF BUSINESS OR INDUSTRY COLLEGE		
13a. STATE MARYLAND			13b. COUNTY FREDERICK		13c. CITY OR TOWN FREDERICK
14. FATHER'S NAME FIRST MIDDLE LAST JOHN SMITH SR			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY JOHNSON		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 220-241683		17. INFORMANT CHARLES E. BROWN FREDERICK
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenocarcinoma of uterus 1790 DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) (this hospital) attended the deceased from 8/26 , 19 81 , to 8/27 , 19 81 , that (1) (we) last saw the deceased alive on 8/27 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE T. Samuel Shin, M.D. DEGREE M.D.				22c. DATE SIGNED 8/27/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) T SAMUEL SHIN				22e. ADDRESS WESTMINSTER MD	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE AUG 29, 1981		23c. NAME OF CEMETERY OR CREMATORY ST JAMES	
23d. LOCATION CITY OR TOWN NEW WINDSOR		23e. COUNTY CARROLL		23f. STATE MD	
24. FUNERAL DIRECTOR NAME D D Hartzler		24b. ADDRESS New Windsor, Md		25a. DATE REC'D. BY REGISTRAR AUG 31 1981	
25b. REGISTRAR'S SIGNATURE James Santhorne					

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

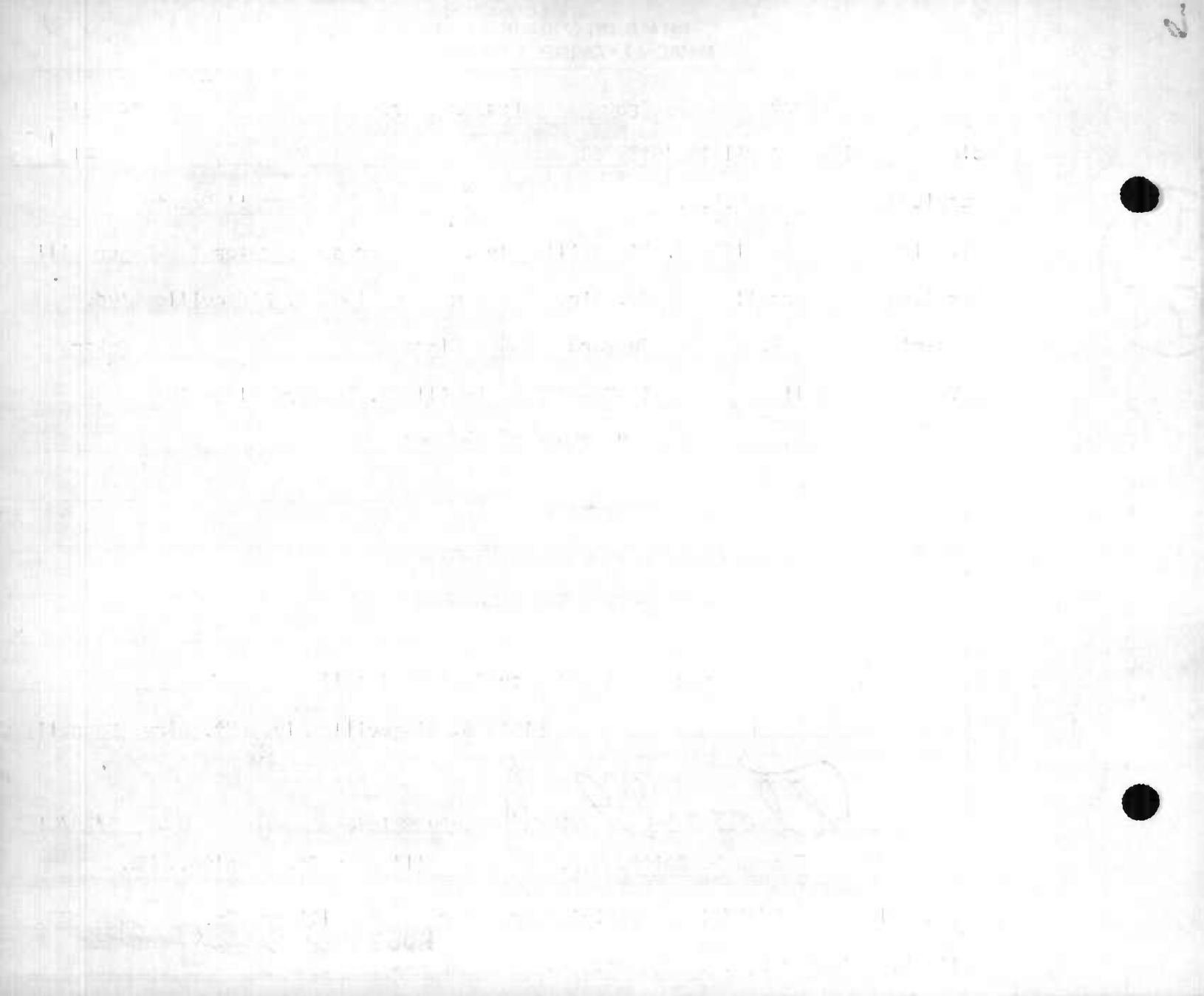
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of case.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
15M 2/80

FOR 1- STATE REGISTRAR										STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21239			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Robert Woodrow Bussard, Sr.										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 8 24 1981										2b. HOUR 1:20			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 12, 1913		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 24 1981										2d. HOUR 1:20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.											
10. CITY OR TOWN OF DEATH Mt. Airy				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1502 S. Ridgeville Blvd.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Press Operator				12b. KIND OF BUSINESS OR INDUSTRY Paper Mill											
13a. STATE Maryland				13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1502 S. Ridgeville Blvd.													
14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Bussard				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Baker																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. WW 11		17. INFORMANT Lucille D. Bussard				17. ADDRESS Item 13													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound of abdomen 9551 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 XXXX 8 24 1981				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject shot self															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1502 S. Ridgeville Blvd, Mt. Airy, Carroll, MD.															
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																							
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Deputy Chief MEDICAL EXAMINER								DATE SIGNED 8/25/81											
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION				23b. DATE 8/27/81		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. MD.													
24. FUNERAL DIRECTOR NAME ADDRESS Olin L. Molesworth, P.A. Damascus, Md.										25. FILED BY REGISTRAR AUG 27 1981													



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Leslie Claybaugh			2a DATE OF DEATH MONTH DAY YEAR 8/25/81			2b HOUR 11 PM			
3 SEX M		4 RACE W		5 DATE OF BIRTH MONTH DAY YEAR 11 13 1900		6 AGE (IN YEARS LAST BIRTHDAY) 80		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) U.S. (PA)		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll MD			
10 CITY OR TOWN OF DEATH MT AIRY		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Pleasant View Nursing Home				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unkn.		12b KIND OF BUSINESS OR INDUSTRY Unkn.	
13a STATE MARYLAND		13b COUNTY Carroll		13c CITY OR TOWN MT AIRY		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS Rt 144	
14 FATHER'S NAME FIRST MIDDLE LAST Unk				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b SOCIAL SECURITY NO. 577 32/390		17 INFORMANT ADDRESS Pleasant View Home - Mt. Airy, Md.			
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest 4960 DUE TO, OR AS A CONSEQUENCE OF: (b) pneumonia DUE TO, OR AS A CONSEQUENCE OF: (c) COPD									APPROPRIATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 10 C.B.S. with contractures, bedridden, Alcoholism, Asc. Azotemia									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f LOCATION STREET CITY OR TOWN COUNTY STATE			
22 I certify that (1) (this hospital) attended the deceased from 8/20/81 19 81 , that (1) (we) last saw the deceased alive on 8/20/81 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death.									
22b SIGNATURE Melvin J. Kordon M.D.						DEGREE M.D.		22c DATE SIGNED 8/25/81	
22d PHYSICIAN'S NAME (TYPE OR PRINT) Melvin J. Kordon M.D.						22e ADDRESS 2000 Century Plaza Columbia Md			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b DATE 8-28-81		23c NAME OF CEMETERY OR CREMATORY Springfield Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Lyskillville Carroll Md		
24 FUNERAL DIRECTOR NAME ADDRESS Harry W. Haight Lyskillville Md.						25a DATE REC'D. BY REGISTRAR AUG 28 1981		25b REGISTRAR'S SIGNATURE Charles J. Hight	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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Q. 1. The first part of the paper is devoted to a discussion of the general theory of the problem. It is shown that the problem is equivalent to a system of linear equations. The coefficients of these equations are determined by the geometry of the problem. The system is solved by the method of least squares. The results are then used to determine the values of the parameters of the problem.

Q. 2. The second part of the paper is devoted to a discussion of the numerical solution of the problem. It is shown that the problem can be solved by the method of least squares. The results are then used to determine the values of the parameters of the problem.

Q. 3. The third part of the paper is devoted to a discussion of the experimental results. It is shown that the results are in good agreement with the theoretical predictions. The results are then used to determine the values of the parameters of the problem.

Q. 4. The fourth part of the paper is devoted to a discussion of the conclusions. It is shown that the problem can be solved by the method of least squares. The results are then used to determine the values of the parameters of the problem.

Q. 5. The fifth part of the paper is devoted to a discussion of the references. It is shown that the problem can be solved by the method of least squares. The results are then used to determine the values of the parameters of the problem.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
CERTIFICATE OF DEATH									
REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR	
MAR		MAURANE		CRISSINGER				8 - 24 - 81	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		7b. HOUR	
FEMALE		CAU		12 - 6 - 75		85		12:45 ^M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
FLORIDA		USA				CARROLL COUNTY		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
NEW WINDSOR		1521 BOWERSOX RD.				HOUSEWIFE		-	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS	
MARYLAND		CARROLL		NEW WINDSOR				1521 STONE CHAPEL RD.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
WIRT S. MYERS		VIOLA BACHELLER							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS					
No		217-18-7286D		VIOLA ROBERTSON DAUGHTER 1521 BOWERSOX RD., NEW WINDSOR, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 METASTATIC CARCINOMA OF THE BREAST DUE TO, OR AS A CONSEQUENCE OF (b) 72 ym. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (D) (this hospital) attended the deceased from 8-5-81, to 8-24-81, that (D) (we) lost saw the deceased alive on 8-5-81, and that in (M) (our) opinion death occurred on the date and hour and from the causes stated above, (D) (we) (did not) view the body after death.								22c. DATE SIGNED 8-24-81	
22b. SIGNATURE Wm. R. Linthicum, M.D.		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS							
Wm. R. LINTHICUM, M.D.		TANEX TOWN, MD. 21787							
23a. BURIAL, CREMATION, REMOVAL (CHECK)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial		8-26-81		Stone Chapel		New Windsor Carroll MD.			
24. FUNERAL DIRECTOR Date Filed		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
254 E. Main St. Westminister Md. 21157		AUG 26 1981		Name Jan. Thaw					

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[Faint, illegible handwriting throughout the page, likely bleed-through from the reverse side.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21242

1. DECEASED-NAME (Type or print) First Middle Last Edgar A Derbaum			2a. DATE OF DEATH 8 Month 20 Day 81 Year 11:40 P M		2b. HOUR
3. SEX Male	4. RACE Cauc.		5. DATE OF BIRTH 6-24-07		6. AGE (In years lost birthday) 74 YRS.
7a. BIRTHPLACE (State or foreign country) Pa.		7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.
10. CITY OR TOWN OF DEATH Westminster, Md.		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 35 Chase Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Process Developer	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.		13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 35 Chase Street
14. FATHER'S NAME First Middle Last Allen R Derbaum			15. MOTHER'S MAIDEN NAME First Middle Last Helen Crawford		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16b. SOCIAL SECURITY NO. None		17. INFORMANT Mrs. Olive Derbaum Westminister Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Intractable congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic heart disease (Acute MI)</u> 5/81					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH instant 12 hrs. 5/81
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Bilateral apical infiltrate</u>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (1) (this hospital) attended the deceased from July, 1969, to August, 1981, that (I) (we) last saw the deceased alive on Aug. 20, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.					
22b. SIGNATURE William R. O'Rourke				22c. DATE SIGNED 8/21/81	
22d. PHYSICIAN'S NAME (Type) William R. O'Rourke, M.D.				22e. ADDRESS 150 W. Main St., Westminster, Md. 21157	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8-24-81		23c. NAME OF CEMETERY OR CREMATORY Pleasant Valley	
23d. LOCATION (City or Town) Westminster		23e. (County) Carroll		23f. (State) Md	
24. FUNERAL DIRECTOR Robert Hyb Puth Jr.				25a. REC'D BY REGISTRAR AUG 26 1981	
25b. REGISTRAR'S SIGNATURE [Signature]					

41



RECEIVED IN THE OFFICE OF THE
DIRECTOR OF THE BUREAU OF
THE ARMY AND NAVAL FORCES

[Faint, mostly illegible text covering the main body of the document, appearing to be a letter or report.]

1942 AUG 28
[Faint text at the bottom of the page, possibly a date and reference number.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

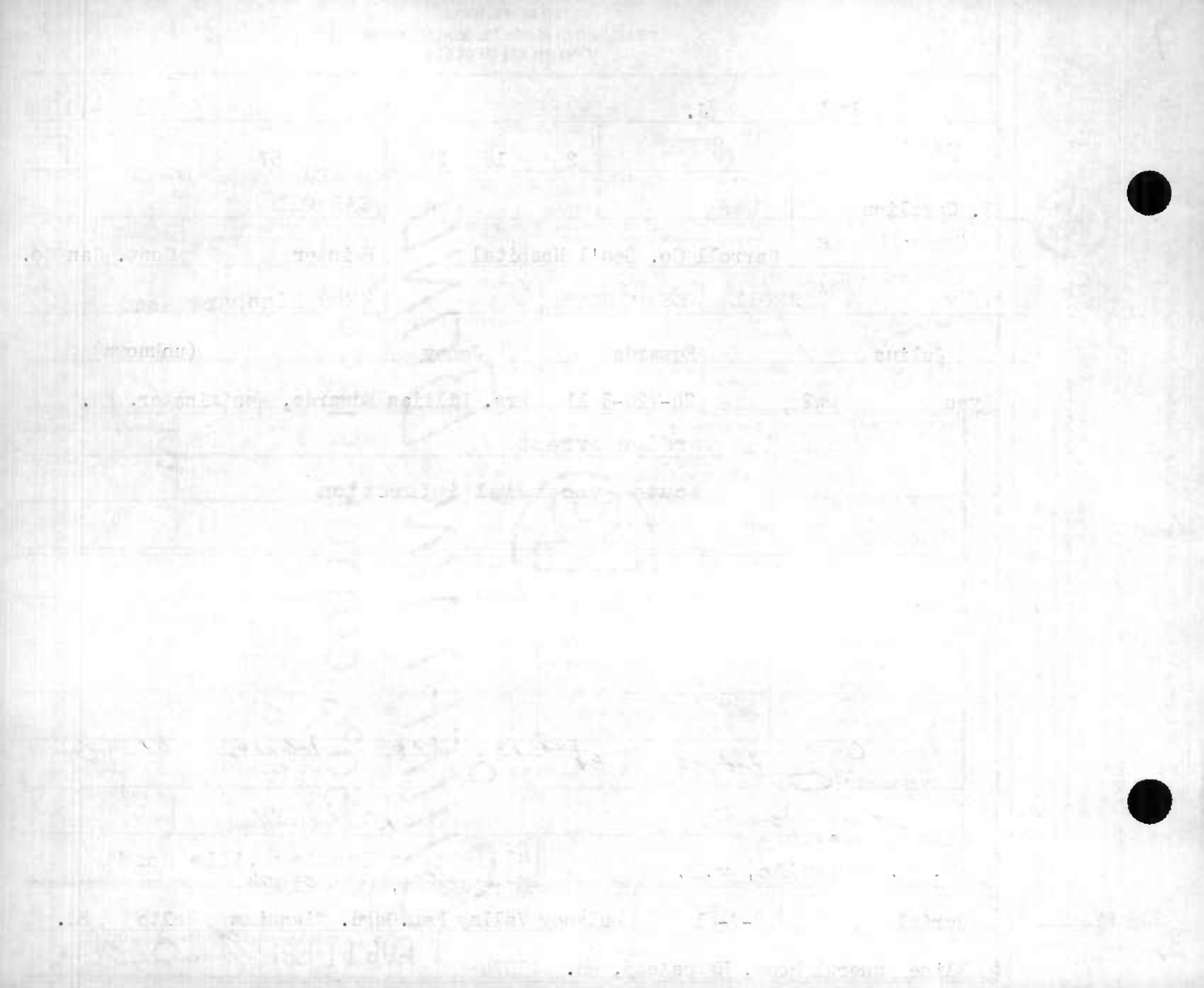
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR					8 1 2 1 2 4 3				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH				
EDWIN J. EDWARDS					MONTH DAY YEAR 8 5 81				
3. SEX					4. RACE				
MALE					WHITE				
5. DATE OF BIRTH					6. AGE (IN YEARS LAST BIRTHDAY)				
MONTH DAY YEAR 2 18 24					57 YRS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)					7b. CITIZEN OF WHAT COUNTRY?				
S. Carolina					USA				
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				
WESTMINSTER					Carroll Co. Gen'l Hospital				
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY				
Painter					Cont. Can Co.				
13a. STATE					13b. COUNTY				
MD					CARROLL				
13c. CITY OR TOWN					13d. STREET ADDRESS				
WESTMINSTER					4249 Rinehart Road				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST Julius Edwards					FIRST MIDDLE LAST Jenny (unknown)				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.				
yes					WW2 24-720-3811				
17. INFORMANT					ADDRESS				
Mrs. Lillian Edwards, Westminster, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Cardiac Arrest									
4100 DUE TO, OR AS A CONSEQUENCE OF									
(b) Acute myocardial infarction									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				
20a. AUTOPSY?					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
YES <input type="checkbox"/> NO <input type="checkbox"/>					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					21b. TIME OF INJURY				
					HOUR A.M. MONTH DAY YEAR P.M. 19				
21d. INJURY OCCURRED					21e. PLACE OF INJURY				
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				
21f. LOCATION					CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from Feb. 19, 1976, to Feb. 16, 1981, that (1) (we) last saw the deceased alive on Feb. 16, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.					22b. SIGNATURE				
					DEGREE				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
D. V. Faustino, M.D.					4111 Lower Beckleysville Road				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)					23b. DATE				
Burial					8-7-81				
23c. NAME OF CEMETERY OR CREMATORY					23d. LOCATION				
Dulaney Valley Mem. Gard.					CITY OR TOWN COUNTY STATE Timonium Balto Md.				
24. FUNERAL DIRECTOR					25a. DATE RECEIVED BY REGISTRAR				
NAME ADDRESS Eline Funeral Home, Hampstead, Md. 21074					25b. REGISTRAR'S SIGNATURE				
					AUG 11 1981				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST MARTHA F. FARVER.				2b. HOUR 14 55			
3. SEX F		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR March 29, 1901		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 80 YRS 4 7	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., Md.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Snyder		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Flickinger		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-24-3060	
17. INFORMANT Helen E. Farver, New Windsor, Md.		17. ADDRESS 15419 Barnes Rd.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 3500 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) HISTORY of diabetes mellitus				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days years years			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Hx of extensive gastric resection & malnutrition; pelvic tumor							
19a. DATE OF OPERATION 7-7		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7-5 , 19 81 to 8-6 , 19 81 , that (I) (we) last saw the deceased alive on 8-6 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Ephraim Barzaga, MD				DEGREE ATTENDING PHYSICIAN		22c. DATE SIGNED 8-6-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EPHRAIM BARZAGA				22e. ADDRESS NEW WINDSOR, Md. 21776			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-10-1981		23c. NAME OF CEMETERY OR CREMATORY Bethany		23d. LOCATION CITY OR TOWN COUNTY STATE Carroll Md.	
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR AUG 11 1981		25b. REGISTRAR'S SIGNATURE [Signature]	

BP

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

100-100000

March 29, 1961

Carroll Co.

W.A.A.

Carroll Co.

Housewife

Carroll Co. General Hospital

Carroll Co.

2222 N. 1st St.

Carroll Co. General Hospital

Carroll Co.

1210 N. 1st St.
Carroll Co. General Hospital

Carroll Co.

Carroll Co.

Carroll Co.

20

Charles W. Miller, Jr., Knoxville, Tenn.

Carroll Co.

2-10-1961

Carroll Co.

Carroll Co.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

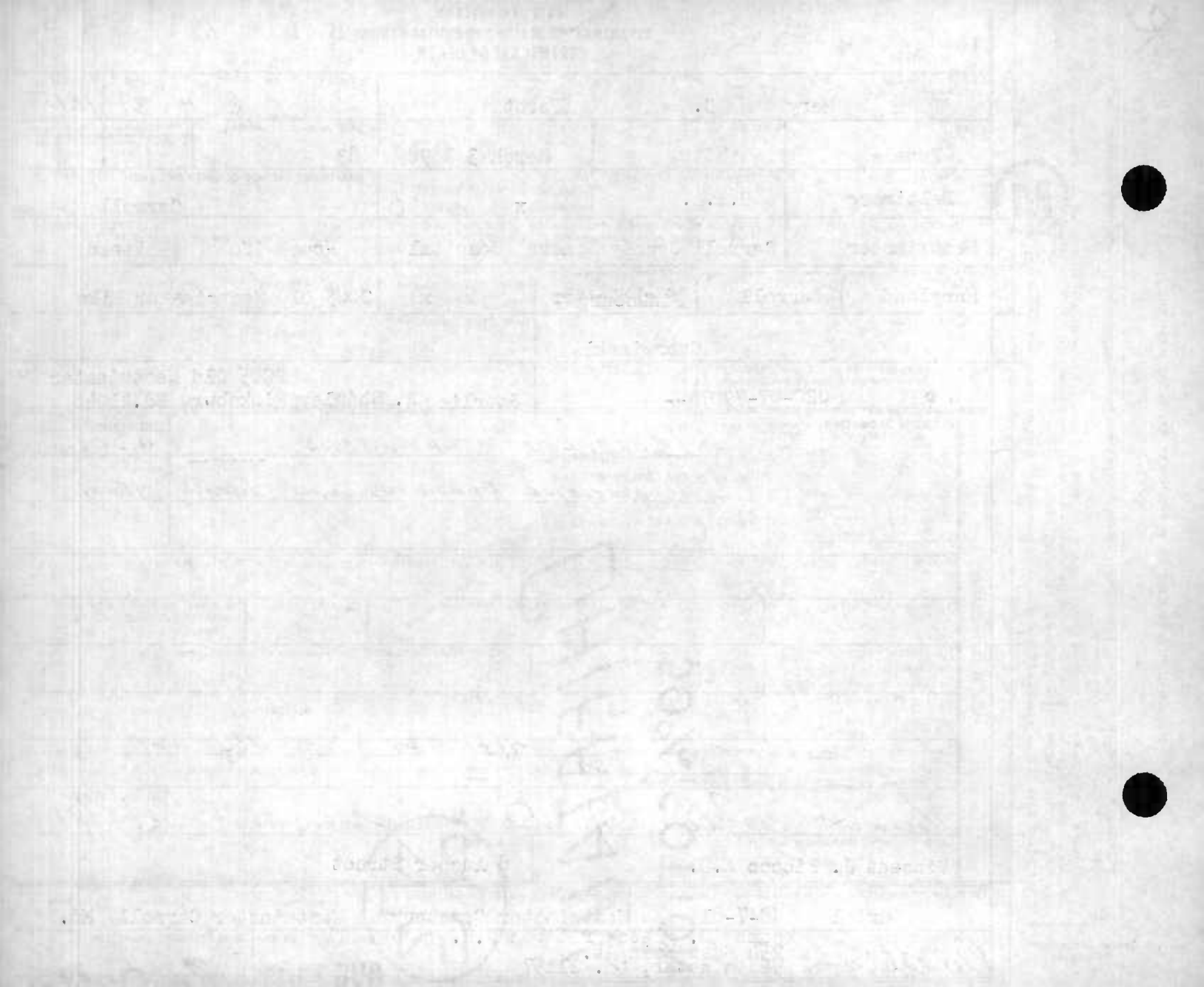
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MEDICAL CERTIFICATION

1- FOR STATE REGISTRAR				DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 2 4 5					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST				2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Mary C. Feret								8 4 81				1815 M	
3 SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.			
Female		White		March 3 1898		83 YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH							
Baltimore		U.S.A.				Carroll MD.							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Westminster		Carroll County General Hospital						Housewife		Retired			
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Carroll		Finksburg				2005 Old Westminster Pike					
14 FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
Czerwinski													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS							
No		220-07-79071----		Sterling A. Shipley Finksburg Md. 21048		2005 Old Westminster Pike							
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBRAL THROMBOSIS</u> <u>4029</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>HYPERTENSIVE CARDIOVASCULAR DISEASE</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>4 DAYS</u> <u>YEARS</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>7/31</u> , 19 <u>81</u> , to <u>8/4</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/4</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Vincent J. Fiocco</u> DEGREE <u>M.D.</u>						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>8/4/81</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS							
Vincent J. Fiocco M.D.						8 Anchor Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE							
Burial		8-7-81		Westminster Cemetery		Westminster Carroll Md.							
24. FUNERAL DIRECTOR NAME		24b. EAST MAIN ST. WESTMINSTER, MD. 21157				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>Thomas D. Fletcher & Son F.H.</u>						AUG 11 1981							

BP



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BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 2 4 6

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Edgar K. Fitch		2a. DATE OF DEATH MONTH DAY YEAR August 24, 1981	
3. SEX MALE		2b. HOUR M	
4. RACE C.		5. DATE OF BIRTH MONTH DAY YEAR 8 21 92	
6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD.	
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FAIRHAVEN	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tree. Textile Factory		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Carroll	
13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 7200 3rd Avenue		14. FATHER'S NAME FIRST MIDDLE LAST Alfred NM Fitch	
15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Kaaz		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN	
16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-09-0073		17. INFORMANT ADDRESS Mrs. Edgar Fitch Same	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration Pneumonia 1850 DUE TO, OR AS A CONSEQUENCE OF (b) Prostate Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) Senile Dementia		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6/23/81, 19 81, to 8/24, 19 81, that (I) (we) last saw the deceased alive on 8/24, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Patrick A. Turner MD		22c. DATE SIGNED 8/24/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PATRICK A TURNER		22e. ADDRESS 7200 E 3rd Ave. Sykesville, Md 21784	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/27/1981	
23c. NAME OF CEMETERY OR CREMATORY Lorraine Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR AUG 31 1981	
25b. REGISTRAR'S SIGNATURE James J. Taylor			

MEDICAL CERTIFICATION

10



WATERBURY
CONNECTICUT 06708

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					REG. NO.	
1. FOR STATE REGISTRAR			2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			MONTH DAY YEAR		MONTH DAY HRS MIN.	
CATHERINE AUGUSTA FOSTER			08 22 81		0835-M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female	White	MONTH DAY YEAR 02 01 1908	73 YRS.		MONTHS DAYS HRS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH			
West Virginia	U.S.A.		Carroll County MD.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminister	90 Timber Ridge		Housekeeper		Our Lady Victory Church	
13a. STATE			13b. CITY OR TOWN	13c. INSIDE CITY LIMITS?	13d. STREET ADDRESS	
Maryland			Carroll	Westminister	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	90 Timber Ridge 21157
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Ira E. McConnell			FIRST MIDDLE LAST Bertha A. Schwinnaman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS	
NO			219-22-8245		Sykesville, Md. 21784	
			William R. Foster, Jr. 5912 Grace Lee Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)						
PART 1. DEATH WAS CAUSED BY:						
IMMEDIATE CAUSE (a) Myocardial infarction						
4100 DUE TO, OR AS A CONSEQUENCE OF (b) H+SCVD						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION						
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						
20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19						
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>						
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)						
21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from November 19 76, to 8-22, 19 81, that (1) (we) last saw the deceased alive on 8-12, 19 81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)						
22b. SIGNATURE DEGREE						
Alva S. Baker						
22c. DATE SIGNED 8-22-81						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						
Alva S. Baker						
22e. ADDRESS 218 Washington Heights Mal Ctr Westminister MD						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)						
Burial						
23b. DATE 8/26/81						
23c. NAME OF CEMETERY OR CREMATORY						
Crestlawn Cemetery						
23d. LOCATION CITY OR TOWN COUNTY STATE						
Marriottsville Howard Md.						
24. FUNERAL DIRECTOR NAME Balto., Md. 21229						
Hubbard Funeral Home, Inc. 4107 Wilkens Ave.						
25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE						
AUG 24 1981						

BP

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	2	4	8
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Carrie Levenia Gilliland</i>										2a. DATE OF DEATH MONTH DAY YEAR <i>8 25 81</i>				2b. HOUR <i>1510 P M</i>		
3. SEX <i>Female</i>			4. RACE <i>White</i>			5. DATE OF BIRTH MONTH DAY YEAR <i>1-16-1912</i>			6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS.			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>			7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH <i>Carroll</i> MD.							
10. CITY OR TOWN OF DEATH <i>Westminster</i>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Carroll County General Hosp.</i>							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Waitress</i>			12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i> 13b. COUNTY <i>Carroll</i> 13c. CITY OR TOWN <i>Westminster</i>										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS <i>65 Timber Ridge Dr.</i>				
14. FATHER'S NAME FIRST MIDDLE LAST <i>Holliday Yates Murphy</i>					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Lora Powder</i>											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>					16b. SOCIAL SECURITY NO. <i>213-16-4365</i>			17. INFORMANT ADDRESS <i>Lora Spex 642 Deer Park Rd. Westminster Md.</i>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <i>oat cell carcinoma lung</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
1629 } DUE TO, OR AS A CONSEQUENCE OF (b) _____																
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>cerebrovascular accident, diabetes mellitus, ASH</i>																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>JUNE 19 81</i> to <i>25 AUG 19 81</i> , that (I) (we) last saw the deceased alive on <i>8/25 81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Robert Espenshade</i> DEGREE								ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>8/25/81</i>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Park W. Espenshade</i>								22e. ADDRESS <i>Anchor St. Westminster</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>8-28-81</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bethesda Cem.</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Sylkesville Carroll Md.</i>						
24. FUNERAL DIRECTOR NAME <i>Paul Zlot</i>								ADDRESS <i>Westminster Md.</i>		25a. DATE RECEIVED BY REGISTRAR <i>AUG 27 1981</i>						
25b. REGISTRAR'S SIGNATURE																

RECEIVED
JAN 21 1962
U.S. AIR FORCE

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only with extra line

Continued from page 124

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1328

Dr. J. J. J. J. J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical certification completed.

BP

DHMH - 16 SOM 1/81
(VRA 15, 4)1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE 8 1 2 1 2 4 9
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) R Eugene Grabill			2a. DATE OF DEATH MONTH DAY YEAR 08 22 81			2b. HOUR 2300M			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 01 09 86		6. AGE (IN YEARS LAST BIRTHDAY) 95 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Cattoll County MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Cattoll County General Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY Cattoll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 58 Timber Ridge	
14. FATHER'S NAME Ruben S GRABILL				15. MOTHER'S MAIDEN NAME SARITA BELLISON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 110-110110		17. INFORMANT MYRTLE GRABILL		ADDRESS Westminster Md			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial infarction 4100 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days Unknown									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) COPD									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) this hospital attended the deceased from 8-17 , 19 81 , to 8-22 , 19 81 , that (we) lost saw the deceased alive on 8-22 , 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (II) we did (did not) view the body after death.									
22b. SIGNATURE Alva S. Baker			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-22-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alva S. Baker			22e. ADDRESS 218 Washington Hgts Mdc Ctr Westminster MD 21157						
23a. BURIAL, CREMATION, REMOVAL (TYPE)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
BURIAL			8-26-81		Uniontown Lutheran		Uniontown Cattoll, Md		
24. FUNERAL DIRECTOR NAME Robert G. B. Smith Jr.			ADDRESS Westminster, Md.		25a. DATE REC'D. BY REGISTRAR (REGISTRAR'S SIGNATURE) AUG 26 1981				

MEDICAL CERTIFICATION



[Faint, mostly illegible handwritten text covering the majority of the page. Some words like 'Graham' and 'Graham' are visible in reverse.]

[Faint handwritten text at the bottom of the page, appearing as bleed-through from the reverse side.]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 2 5 0

1. FOR
STATE
REGISTRAR

REG. NO.

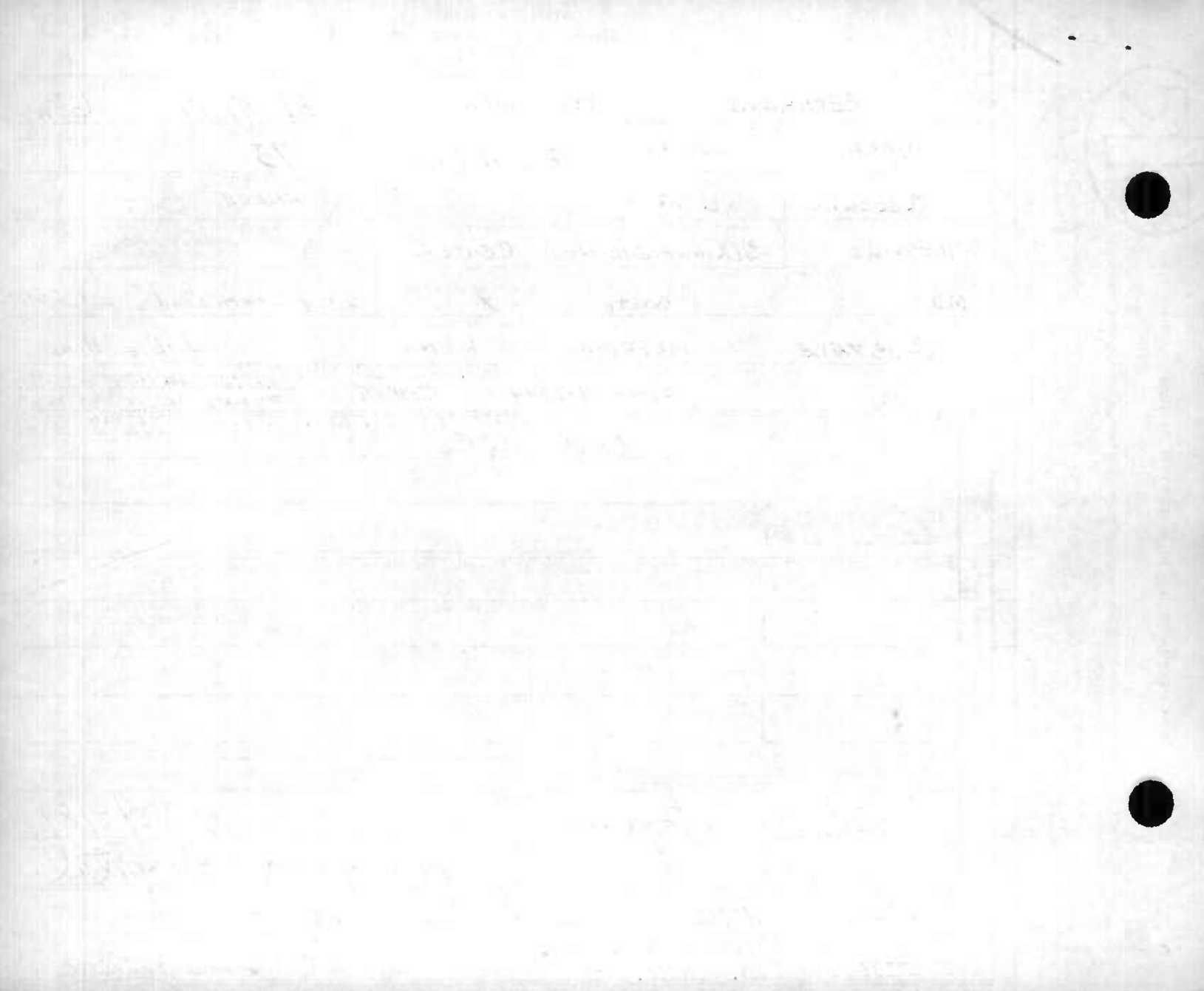
1. DECEASED NAME (TYPE OR PRINT) BERNHARD			FIRST MIDDLE LAST HOFFMAN			2a. DATE OF DEATH MONTH DAY YEAR 8/5/81			2b. HOUR 6³⁰ A M		
3. SEX MALE			4. RACE white			5. DATE OF BIRTH MONTH DAY YEAR 8/11/07			6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Georgia			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL COUNTY MD.		
10. CITY OR TOWN OF DEATH SYKESVILLE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (GIVE STREET ADDRESS) SPRINGFIELD HOSP. CENTER						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) NONE		
13a. STATE MD			13b. COUNTY BALTO.			13c. CITY OR TOWN BALTO.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST GUSTAVE			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LENA			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 214-74-8514		
17. NAME OF DECEASED MRS. BEATRICE ROSENTHAL			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) old age 7970 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____			19. ADDRESS 6711 PARK HTS. AVE., APT. 411			20. DATE OF INTERVIEW BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. William Lee						DEGREE MD			22c. DATE SIGNED 8/5/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Lee						22e. ADDRESS Springfield Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 8/6/81			23c. NAME OF CEMETERY OR CREMATORY BALTIMORE HEBREW			23d. LOCATION CITY OR TOWN COUNTY STATE REISTERSTOWN BALTO MD		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC.						25a. DATE REC'D. BY REGISTRAR AUG 12 1981			25b. REGISTRAR'S SIGNATURE James J. [Signature]		
6010 REISTERSTOWN RD. BALTO., MD 21215											

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3

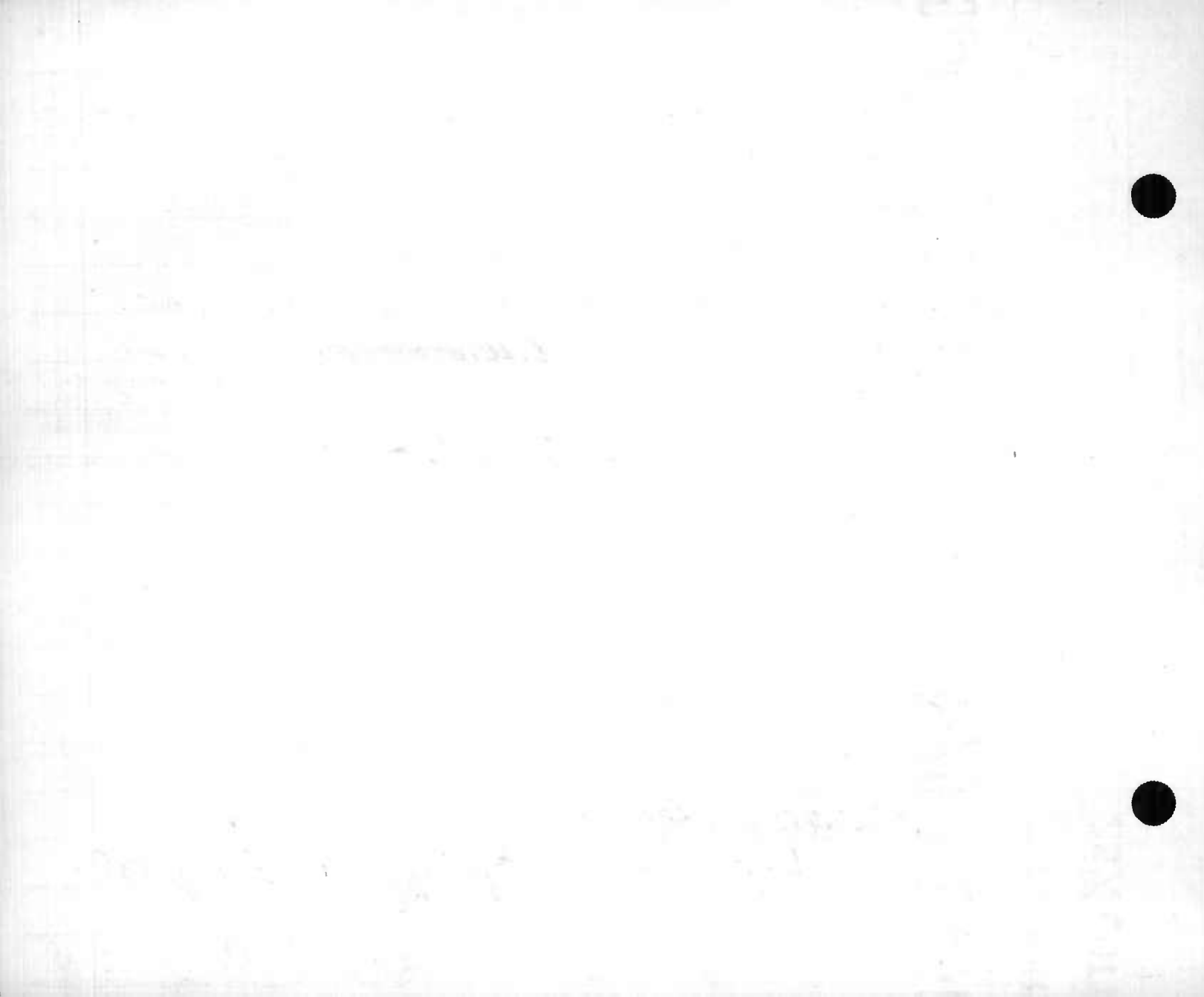
FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 2 5 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) SHIRLEY MAE HOLCOMB			2a. DATE OF DEATH MONTH DAY YEAR 8-19-81			2b. HOUR 5 45 AM					
3 SEX Female		4 RACE Negro		5 DATE OF BIRTH MONTH DAY YEAR 11-4-35		6 AGE (IN YEARS LAST BIRTHDAY) 45 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10 CITY OR TOWN OF DEATH SYKESVILLE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SPRINGFIELD Hosp. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1908 WALBROOK AVE.		
14 FATHER'S NAME FIRST MIDDLE LAST Robert Johnson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LILLIE MAE BATTLE			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 214-38-3289	
17 INFORMANT NAME ADDRESS Robert Johnson 1908 WALBROOK AVE BALTIMORE, MD.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Heart attack 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Dr. William Lee, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) W. Lee, M.D.			22e. ADDRESS Springfield Hospital								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/24/81		23c. NAME OF CEMETERY OR CREMATORY Westview Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Md.				
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H Inc. 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR AUG 20 1981		25b. REGISTRAR'S SIGNATURE James J. Martin			



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8

1

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2

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Owen G. Hunt			2a. DATE OF DEATH MONTH DAY YEAR 8 28 1981			2b. HOUR 11:28 AM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3 21 10		6. AGE (IN YEARS LAST BIRTHDAY) 71 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County Gen				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Balto. City Police	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) Md. STATE 13b. CITY OR TOWN Baltimore				13c. CITY OR TOWN Reisterstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 107 Meel Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST John W. Hunt				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Fannie Roney					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-16-8050		17. INFORMANT ADDRESS Mrs. Delia A. Hamberry Reisterstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> 2507 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes after operation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign the body after death.									
22b. SIGNATURE M. Christy						DEGREE		22c. DATE SIGNED 8/28/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) M. Christy						22e. ADDRESS Carroll Co. Hospital			
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE Aug. 31, 1981		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md. 21136						25a. DATE REC'D. BY REGISTRAR AUG 31 1981		25b. REGISTRAR'S SIGNATURE Rame Jan Nathan	

RECEIVED
JUN 10 1961

TO: Mr. J. Edgar Hoover, Director, Federal Bureau of Investigation, Washington, D.C.
FROM: Mr. [Name], [Address], [City], [State]
SUBJECT: [Subject Line]
[Body of the letter, mostly illegible]

[Continuation of the letter body, mostly illegible]

Very truly yours,
[Signature]
[Name]
[Title]

cc: [List of recipients, mostly illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 2 5 3

REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Effie Bell Justice			2a. DATE OF DEATH MONTH DAY YEAR August 19, 1981		2b. HOUR 7:00 AM								
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR April 28, 1906		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS 3 21		IF UNDER 24 HRS HOURS MIN. 7 00			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.							
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2137 Flag Marsh Road				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2137 Flag Marsh Road					
14. FATHER'S NAME FIRST MIDDLE LAST George Green				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Hatfield									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-14-0445		17. INFORMANT ADDRESS Oscar N. Justice, Same As #13									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Recurrent Stroke</u> 4029 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral Hemorrhage - Hypertension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hypertensive C.V.D.</u> Approximate interval between onset and death <u>Sudden</u> <u>3 years</u> <u>10 yrs</u>													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 15</u> , 19 <u>81</u> , to <u>Aug 19</u> , 19 <u>81</u> , that (I) (<u>we</u>) lost saw the deceased alive on <u>June 26</u> , 19 <u>81</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (<u>did</u>) (<u>did not</u>) view the body after death.													
22b. SIGNATURE <u>Sani Okutman MD</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>8.19.81</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sani A. Okutman, M.D.				22e. ADDRESS Obrecht Road Sykesville, Md.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-22-1981		23c. NAME OF CEMETERY OR CREMATORY Poplar Springs				23d. LOCATION CITY OR TOWN COUNTY STATE Poplar Springs, Howard, Md					
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.				25a. DATE REC'D. BY REGISTRAR AUG 24 1981								25b. REGISTRAR'S SIGNATURE <u>James J. ...</u>	

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.



August 10, 1951
Mr. J. Edgar Hoover
Washington, D.C.

Dear Mr. Hoover:
I am writing to you regarding the matter of the
Missouri State Highway Commission.

The Missouri State Highway Commission has been
asked to consider the matter of the
Missouri State Highway Commission.

I am writing to you regarding the matter of the
Missouri State Highway Commission.

I am writing to you regarding the matter of the
Missouri State Highway Commission.

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Missouri State Highway Commission.

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Missouri State Highway Commission.

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Missouri State Highway Commission.

I am writing to you regarding the matter of the
Missouri State Highway Commission.

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81

21254

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE OF DEATH MONTH DAY YEAR			2c. HOUR A. M.		
Mary Catherine Kefauver						8 13 81			6 M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR IF UNDER 24 HRS		
Female		White		MONTH DAY YEAR 10 17 16		64 YRS.			MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Carroll MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Union Bridge		2 S. Farquhar St.				seamstress			sewing factory		
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		
Maryland			Carroll		Union Bridge		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2 S. Farquhar St.		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST								
Henry Fogle			Mary Susan Winters								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS					
No			none			214-16-0938 Catherine Mitten Union Bridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cancer melanosis Mediastinum</u>											
DUE TO, OR AS A CONSEQUENCE OF (b) <u>heart - BONES - Liver</u>											
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer Rt. Lung</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
6 months ago			R.T. Lung Lobectomy								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
			P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> 19 <u>81</u> , to <u>8/6</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>8/6</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE						DEGREE			22c. DATE SIGNED		
NICHOLAS P. FURIS MD						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			8/13/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)						22e. ADDRESS					
NICHOLAS P. FURIS						801 TOLL HOUSE AVE. FREDERICK					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			8/16/81			Winters Cemetery			near New Windsor Carroll Md.		
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
D. D. Ziebler Union Bridge, Md.						AUG 17 1981			James J. [Signature]		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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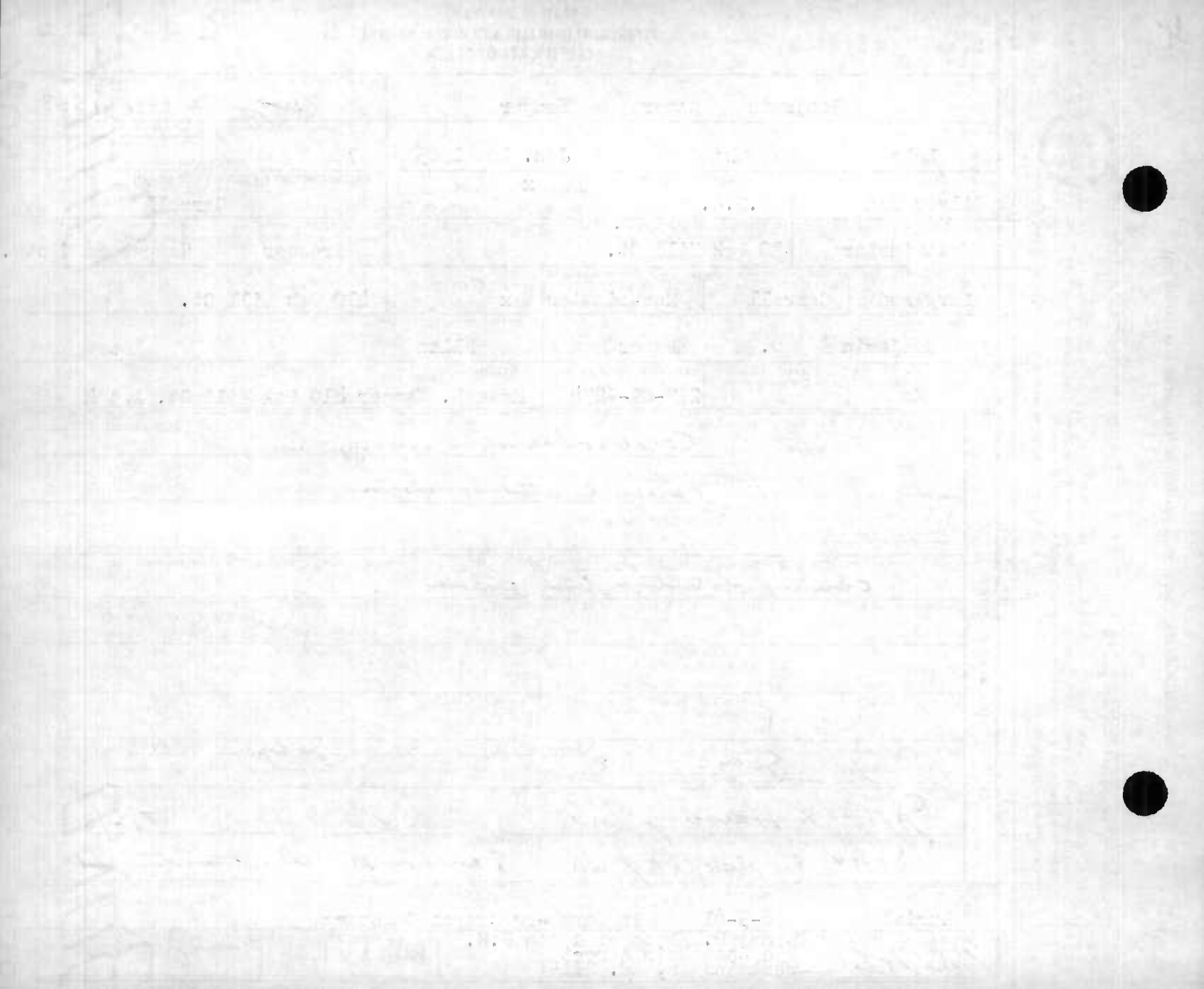
1913 - 1914

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Benjamin Albert Kemper					2a. DATE OF DEATH MONTH DAY YEAR Aug 2, 1981			2b. HOUR 1533 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Jan. 18 1905		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Silver Run		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 410 Oak Hill Ct.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Presser		12b. KIND OF BUSINESS OR INDUSTRY Hampstead Cloth.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 410 Oak Hill Ct.		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin D. Kemper					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellen Moose				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-09-9274		17. INFORMANT ADDRESS Rose L. Kemper 410 Oak Hill Ct. Apt 4					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebrovascular insufficiency</u> 4370 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>DUE TO, OR AS A CONSEQUENCE OF</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). <u>Chronic obstructive lung disease</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>June 15, 1981</u> to <u>July 6, 1981</u> , that (I) (we) last saw the deceased alive on <u>July 6, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE DEGREE <u>John S. Harsney, M.D.</u>					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 5/2/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN S. HARSNEY, M.D.					22e. ADDRESS 8 anchor st. Westminster Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-5-81		23c. NAME OF CEMETERY OR CREMATORY Spynersburg Church Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE		
24. FUNERAL DIRECTOR NAME Val Hotel					24b. ADDRESS 254 East Main Street Westminster, Md. 21157		25. DATE REC'D. BY REGISTRAR AUG 10 1981		
26. REGISTRAR'S SIGNATURE <u>Thomas D. Fletcher & Son F.H.</u>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death and retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DHMH-16 1/71 30M
(VR A15 (4))

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

21256

1. DECEASED-NAME (Type or print) First Middle Last James Grady Key Jr.			2a. DATE OF DEATH Month Day Year Aug 2 1981		2b. HOUR 2210M
3. SEX male	4. RACE white	5. DATE OF BIRTH Aug 3, 1927		6. AGE (In years lost birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Carroll Md.	
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Carroll Co. Gen. Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) purchasing agent	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Carroll	13c. CITY OR TOWN Westminster	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 632 Old Tanettown Rd.
14. FATHER'S NAME First Middle Last James Grady Key Sr			15. MOTHER'S MAIDEN NAME First Middle Last Eleanor Senton		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) WWII 212-22-3109		17. INFORMANT Address Ella Jean Key S/A	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic carcinoma</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Squamous cell carcinoma of the lung</u> DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 30, 1981</u> , to <u>Aug 2, 1981</u> , that (I) (we) last saw the deceased alive on <u>Aug 2, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <u>John S. Harshey, M.D.</u>		DEGREE M.D.		22c. DATE SIGNED 8/2/81	
22d. PHYSICIAN'S NAME (Type) JOHN S. HARSHEY, M.D.		22e. ADDRESS 8 Ambler St. Westminster, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/5/81		23c. NAME OF CEMETERY OR CREMATORY Meadow Branch	
23d. LOCATION (City or Town) (County) (State) Westminster Carroll MD.		24. FUNERAL DIRECTOR ADDRESS PRITTS FUNERAL HOME, WESTMINSTER, MD		25a. REC'D BY REGISTRAR DATE AUG 1 1981	
25b. REGISTRAR'S SIGNATURE <u>Thomas J. [Signature]</u>					

STATE OF CALIFORNIA
DEPARTMENT OF LAND AND MINES
DIVISION OF LAND



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by the hospital or attending physician.

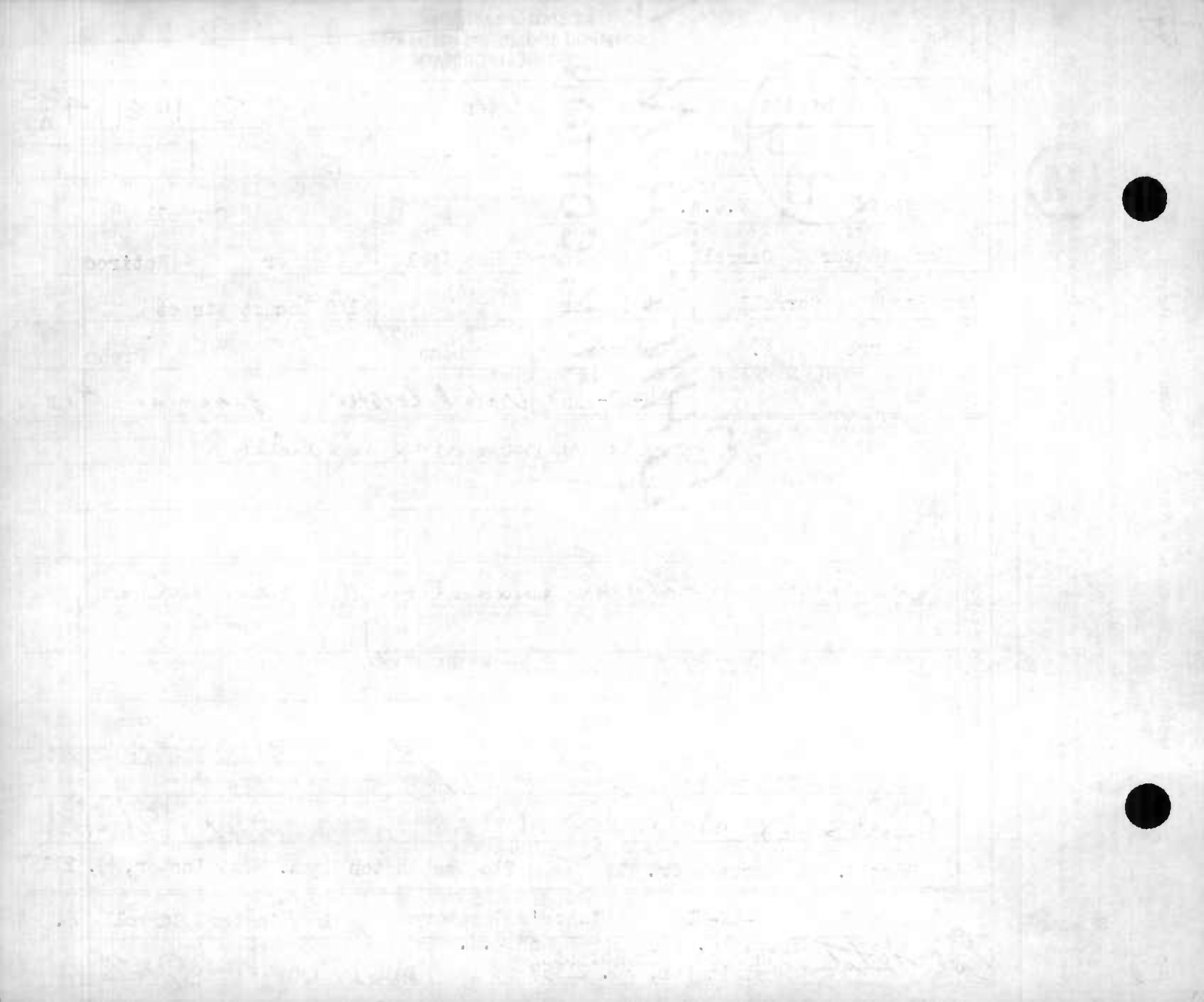
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 336-1235.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 1 2 1 2 5 7	
1 - FOR STATE REGISTRAR					REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Leslie Brehm Leister					2a. DATE OF DEATH 8 10 81 4:22 AM	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 9 19 1905		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hamstead		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.		
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY Retired				
13a. STATE Maryland		13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		
14. FATHER'S NAME George A. Leister		15. MOTHER'S MAIDEN NAME Lena Brehm		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-03-7359		17. INFORMANT Viola R. Leister		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: previous myocardial infarction (11 years earlier)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/10 1981, to 8/10 1981, that (I) (we) last saw the deceased alive on 8/10 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-10-81		23c. NAME OF CEMETERY OR CREMATORY Leister's Cemetery		
23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md.		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE		
24. FUNERAL DIRECTOR NAME Thomas D. Fletcher & Son F.H. 254 West Main Street Westminster, Md. 21157		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE AUG 12 1981		

BP



REG. NO.

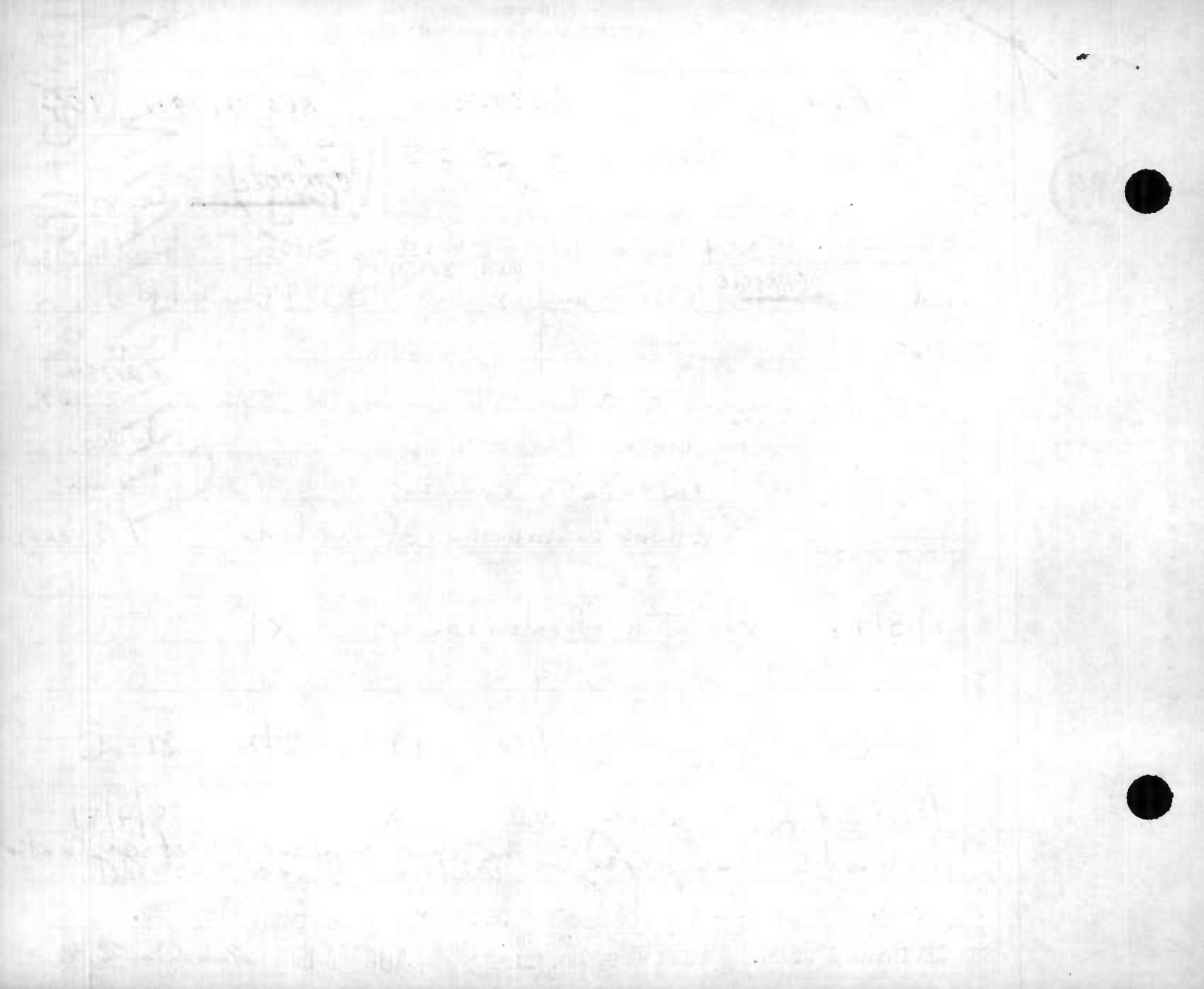
MEDICAL CERTIFICATION

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16 50M 1/81
(VRA 15, 4)

25a DATE REC'D. BY REGISTRAR 25b REGISTRAR'S SIGNATURE

AUG 6 1981 *James J. Martin*



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAYS ARE NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN FILES FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DMMH - 17
(VR A15 ME (5))
15M 7/77

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR
STATE
REGISTRAR

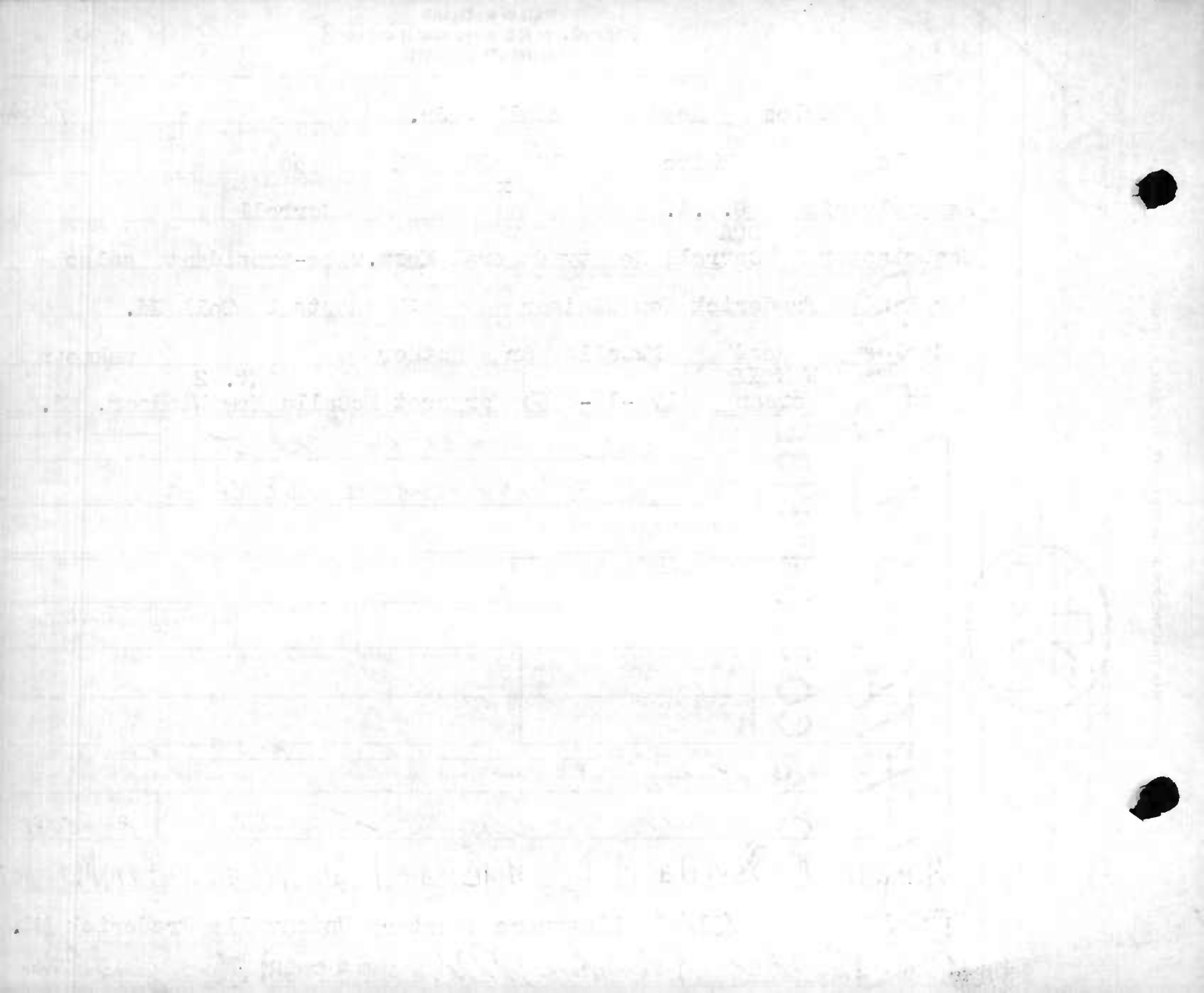
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE KNOWN OF DEATH ESTI-MATED			MONTH DAY YEAR			2d. MONTH DAY YEAR		
JOSEPH ROMAN LOSS						8 5 81			8 5 81			4 8 81		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	IF UNDER 1 YR.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR			2d. MONTH DAY YEAR		
MALE	WHITE	5 19 31	50 YRS.			8 5 81			8 5 81			4 8 81		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
MASS.			U.S.A.						CARROLL					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
WESTMINSTER			CARROLL COUNTY HOSPITAL			ACCOUNTANT								
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
MARYLAND			CARROLL			SYKESVILLE			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			6722 SYKESVILLE RD		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST			FIRST MIDDLE LAST											
WILLIAM LOSS ANNA			KOSNOSKA											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
YES			KOREMA			015-22-7463			MARGARET SYLX Sykesville, Md.					
18. CAUSE OF DEATH (Enter only one cause per line or (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:														
IMMEDIATE CAUSE (a)														
4100 Cardiac Arrhythmia & Infection Complicating														
DUE TO, OR AS A CONSEQUENCE OF														
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.														
(b) Theophylline toxicity														
DUE TO, OR AS A CONSEQUENCE OF														
(c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).														
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?		
												YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
				P.M. 19										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION						
								STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, and on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion														
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED						
Richard Jones				M.D. [Signature]				8/7/81						
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS										
Richard Jones				Westminster, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATOR				23d. LOCATION		
BURIAL				8/8/81				LIBERTY BAPTIST CEMETERY				LISBON		
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE						
NAME ADDRESS				AUG 11 1981				[Signature]						
Harry W. Haight				Sykesville, Md.										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Post-mortem may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at 275-6035.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 2 6 0			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Carlos Reed McCalla, Jr.				MONTH DAY YEAR 8 27 81			
3. SEX				2b. HOUR			
Male				9:05 AM			
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
White		MONTH DAY YEAR 10 22 22		58 YRS.		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Pennsylvania		U.S.A.		Carroll		MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Westminster		Carroll County General Hosp.		vice-president sales			
13a. STATE				13b. STREET ADDRESS			
Maryland				Route 2 Toll Rd.			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME			
FIRST MIDDLE LAST Carlos Reed McCalla, Sr				FIRST MIDDLE LAST Esther unknown			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.			
Yes				Korean 179-16-8554			
17. INFORMANT				ADDRESS			
Margaret McCalla New Windsor, Md.				Rt. 2			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u> 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>ACUTE MYOCARDIAL INFARCTION</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____							
19a. DATE OF OPERATION							
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 19 8-27 to 19 81, that (I) (we) last saw the deceased alive on 8-27 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				22c. DATE SIGNED			
Manuel J. Sevilla, M.D.				8-28-81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Manuel J. Sevilla, M.D.				419C Malcolm Dr. Westminster, Md. 21157			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE			
Burial				8/31/81			
23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE			
Linganore Cemetery				Unionville Frederick Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR			
A. D. Lutzke				AUG 31 1981			
25b. REGISTRAR'S SIGNATURE				25c. REGISTRAR'S NAME			
James J. Nathan				James J. Nathan			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Gertrude Margaret Medley					2a. DATE OF DEATH MONTH DAY YEAR August 22, 81			2b. HOUR 9:30 A.M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7- 203- 1901		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 9:30 A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10. CITY OR TOWN OF DEATH Sykesville		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Golden Age Guest Home, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler		12b. KIND OF BUSINESS OR INDUSTRY government	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Carroll		13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST William Klingenstein			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Strieb			13e. STREET ADDRESS 355 Jasontown Rd.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. none		17. INFORMANT 355 Jasontown Rd. Charlotte Mullich Westminster, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Left Lower Lobe Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3-weeks
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. H. Caricofe						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. H. Caricofe						22e. ADDRESS 104 N. Main St. Union Bridge, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/25/81		23c. NAME OF CEMETERY OR CREMATORY Baltimore National Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		
24. FUNERAL DIRECTOR NAME S. D. Zantler						ADDRESS New Windsor, Md.		25a. DATE REC'D. BY REGISTRAR AUG 25 1981	
						25b. REGISTRAR'S SIGNATURE Glenn J. Foster			

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DHMH - 17
(VR A15 ME (5))
15M 7/77

FOR STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 21262																							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Angeline Catherine Meixner										2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 8 13 81										2b. DATE OF DEATH ESTIMATED MONTH DAY YEAR 8 13 81																																	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 1 1893		6. AGE (IN YEARS) LAST BIRTHDAY YRS. 88		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 13 81		7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore										7b. CITIZEN OF WHAT COUNTRY? U.S.A.										8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD									
10. CITY OR TOWN OF DEATH Westminster										11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hospital										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)										12b. KIND OF BUSINESS OR INDUSTRY																							
13a. STATE Maryland										13b. COUNTY Carroll										13c. CITY OR TOWN Westminster										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										13e. STREET ADDRESS 521 Mark Drive													
14. FATHER'S NAME FIRST MIDDLE LAST Markas										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maria Regner										16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No										16b. SOCIAL SECURITY NO. 214-74-4492										17. INFORMANT ADDRESS Agnes F. Rush Jama 25 #13													
18. CAUSE OF DEATH (Enter only one cause per line (a), (b), and (c). PART I DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) <u>Atherosclerotic Cardio Cerebral Vascular Disease</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <u>Diabetes</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Year										PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Right Hip & Wrist Fracture Due to Fall</u>																																	
19a. DATE OF OPERATION 9 Aug 81										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <u>Right Hip Fracture</u>										20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>																																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>										21b. TIME OF INJURY A.M. MONTH DAY YEAR 8 8 81										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) <u>Fall in bed room</u>																																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <u>Home</u>										21f. LOCATION CITY OR TOWN COUNTY STATE <u>7312 First Ave Sykesville Carroll Md.</u>																																	
22a. I certify that I took charge of the remains described above held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion										22b. ACTUAL SIGNATURE <u>Richard Jones</u>										22c. MEDICAL EXAMINER <u>Richard Jones</u>										22d. DATE SIGNED 14 Aug 81																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial										23b. DATE 8-17-81										23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer										23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Balt. City Md.																							
24. FUNERAL DIRECTOR NAME <u>Fletcher</u>										24b. ADDRESS 74 East Main Street										25. DATE REC'D. BY REGISTRAR AUG 18 1981										25b. REGISTRAR'S SIGNATURE <u>Thomas D. Fletcher & Son F.H.</u>																							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. GIVE PAGE 4 TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



1981 01 20A

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

81

21263

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EUNICE CASS MERCER		2a. DATE OF DEATH MONTH DAY YEAR AUGUST 9 81		2b. HOUR 9:10 M
3. SEX Female	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 5 13 09		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) JAMAICA	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL County Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	12b. KIND OF BUSINESS OR INDUSTRY Home
13a. STATE Md.		13b. COUNTY CARROLL	13c. CITY OR TOWN Woodbine	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST John R. Marley-Cass		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Miller		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. ?		17. INFORMANT ADDRESS Harold Mercer - Woodbine, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1549 IMMEDIATE CAUSE (a) Terminal cancer of pancreas DUE TO, OR AS A CONSEQUENCE OF metastasis to kidney (b) & disseminated DUE TO, OR AS A CONSEQUENCE OF abst. jaundice (c) 				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)				
19a. DATE OF OPERATION 7/14/81		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Terminal ca		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		
21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 7/13 , 19 81 , to 8/9 , 19 81 , that (I) (we) last saw the deceased alive on 8/9/81 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Pius y. Cho		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/9/81
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Pius y. CHO		22e. ADDRESS Westminster, Md.		
23a. BURIAL, CREMATION, REMOVAL (BY) Burial	23b. DATE 8-13-81	23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery	23d. LOCATION CITY OR TOWN COUNTY STATE Manassas Howard Md.	
24. FUNERAL DIRECTOR NAME Harry W. Haight		ADDRESS Lysandville, Md.		

MEDICAL CERTIFICATION

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NOTED

August 29, 1911
Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 21st inst. in relation to the matter of the proposed new hospital for the insane at the State Hospital, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

Very respectfully,
J. W. [Signature]
[Title]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 of 1

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death. Page 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of death.

BP

DHMH - 16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	2	6	4		
1- FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT) Charles Albert Morgan, Sr.										2a. DATE OF DEATH MONTH DAY YEAR 8-16-81							2b. HOUR 0332 M	
3. SEX Male			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR 3 7 11			6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS			IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.									
10. CITY OR TOWN OF DEATH Westminster			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll County General Hosp.							12a. USUAL OCCUPATION main entrance worker			12b. KIND OF BUSINESS OR INDUSTRY state roads					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland										13b. COUNTY Carroll		13c. CITY OR TOWN New Windsor		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 10904 McKinstry Mills Rd.		
14. FATHER'S NAME FIRST MIDDLE LAST Benjamin Franklin Morgan					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisy Louise Lare					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none		17. INFORMANT Irene V. Morgan New Windsor, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>acute respiratory failure</u> 4960 DUE TO, OR AS A CONSEQUENCE OF (b) <u>chronic obstructive pulmonary disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>with myocardial infarction</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>home</u> <u>year</u> <u>day</u>										PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <u>diabetes mellitus; peripheral vascular disease</u> <u>congestive heart failure</u>								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from <u>8-5</u> 19 <u>81</u> , to <u>8-16</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>8-16</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										22b. SIGNATURE Ephraim Barzaga, M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							22c. DATE SIGNED 8-16-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) EPHRAIM BARZAGA					22e. ADDRESS NEW WINDSOR, Md. 21776													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8/19/81		23c. NAME OF CEMETERY OR CREMATORY Union Chapel Cemetery			23d. LOCATION hr. Libertytown, Frederick Md.										
24. FUNERAL DIRECTOR NAME D. D. Zerkow New Windsor, Md.					25a. DATE REC'D BY REGISTRAR AUG 18 1981					25b. REGISTRAR'S SIGNATURE James J. Harshbarger								

MEDICAL CERTIFICATION



BP

DHMH - 16 50M 1/76
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR 1 - STATE REGISTRAR					8 1 2 1 2 6 5				
1. DECEASED NAME (TYPE OR PRINT)					2a. DATE OF DEATH MONTH DAY YEAR				
Laura E. Nash					8 26 81 10 PM				
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR 6 14 1894		87 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		USA				Carroll Co. MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
New Windsor		2000 Old New Windsor Road				Hwf			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					13d. INSIDE CITY LIMITS?				
13a. STATE 13b. COUNTY 13c. CITY OR TOWN					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
Maryland Baltimore Upperco					13e. STREET ADDRESS				
					Mt. Carmel Road				
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST					FIRST MIDDLE LAST				
Joseph Ensor					Delilah Ensor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT		
no					220-50-3928		Mrs. Rosalie Barrett, New Windsor, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>HEPATIC FAILURE</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>HEPATIC CARCINOMA OF LIVER</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>1991</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
23a. SIGNATURE					DEGREE			22c. DATE SIGNED	
Josae C. LARRO, M.D.					ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			8-27-81	
23d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS				
Josae C. LARRO, M.D.					Hampstead, Md. 21074				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			8-28-81		Cedar Grove Cemetery		Parkton Balto Md.		
24. FUNERAL DIRECTOR NAME ADDRESS					25a. DATE REC'D. BY REGISTRAR				
Eline Funeral Home, Hampstead, Md. 21074					AUG 31 1981				



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	2	6	6
1. FOR STATE REGISTRAR										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Beryl Buckingham Penn										2a. DATE OF DEATH MONTH DAY YEAR August 11, 1981				2b. HOUR 1525 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR May 9, 1899		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS		IF UNDER 1 YEAR MONTHS DAYS 3 2		IF UNDER 24 HRS HOURS MIN. 15 25						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.										
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. General Hospital						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY						
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Carroll 13c. CITY OR TOWN Mt. Airy										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2914 Gillis Falls Rd.				
14. FATHER'S NAME FIRST MIDDLE LAST Ottis B. Buckingham					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella May Harrison											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 219-20-0278		17. INFORMANT ADDRESS Rita W. Nikirk, Mt. Airy, Md. 4510 Hickory Lane										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic heart disease</u> (c) <u>Perinephritic abscess left kidney</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE Juan A. Suriel, M.D.						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-12-81								
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JUAN A. SURIEL, M.D.						22e. ADDRESS CARROLL CO. GEN. HOSP.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-15-1981		23c. NAME OF CEMETERY OR CREMATORY Pine Grove		23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy, Carroll, Md.										
24. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.						25. DATE REC'D. BY REGISTRAR THE REGISTRAR'S SIGNATURE AUG 14 1981										



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		20. DATE OF DEATH		MONTH		DAY		YEAR		26. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		8		7 81 4 ⁰⁰ AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Cauc		8 28 89		91 YRS.		11 10		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				MD.	
West Virginia		USA				Carroll					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Westminster		WNC		CLERICAL		OFFICE					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
md.		Calvert		North Beach		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 537			
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
Samuel		SARA		710		175-10-9482		SARAH Esmerthy		North Beach, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4860		Pneumonia						~ 36 hours			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)		AASCUD		Diabetes							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		HOUR A.M. MONTH DAY YEAR									
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, EARM, ETC.)		21f. LOCATION							
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that (1) this hospital attended the deceased from 8-12-1978, to 8-7-1981, that (we) lost saw the deceased alive on 8-6-1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If (a) did not see the body after death, above (b) did not see the body after death.)		22b. SIGNATURE		DEGREE		22c. DATE SIGNED					
		Alva S. Baker				8-7-81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>							
Alva S. Baker		2218 Washington Heights Med Ctr Westminster MD 21157									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY STATE	
CREMATION		8-8-81		Security Process		Baltimore		Baltimore		Md	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
Robert Kyle Butler Jr.		AUG 12 1981		James J. [Signature]							

REPORT
OF

OFFICE

CLERK

OF THE

THE

STATE OF NEW YORK

REPORT

1907

OFFICE OF THE CLERK OF THE SENATE
STATE OF NEW YORK
JANUARY 10, 1907

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

FOR
1 - STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Franklin Eugene Raver, Jr.			2a DATE OF DEATH MONTH DAY YEAR 8-13-81			2b HOUR 1928 M			
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 3 9 1927		6 AGE (IN YEARS LAST BIRTHDAY) 54 YRS		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.			
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co. Gen'l Hospital				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Suburban Propane		12b KIND OF BUSINESS OR INDUSTRY Gas	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a STATE Md.		13b COUNTY Carroll		13c CITY OR TOWN Hampstead		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 900 S. Main Street	
14 FATHER'S NAME FIRST MIDDLE LAST F. Eugene Raver, Sr.				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hazel Alban					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 213-24-9734		17 INFORMANT ADDRESS Mrs. Beverly Raver, Hampstead, Md. 21074			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ventricular fibrillation</u> 4100 } DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>over劳累</u>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instant</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from <u>3-20-</u> 19 <u>81</u> to <u>8-13-</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>3-20-</u> 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <u>Chitrachedu Naranna</u>				DEGREE MD				22c. DATE SIGNED 8/13/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHITRACHEDU NARANNA.				22e ADDRESS 174-E Main St. WESTMINSTER MD 21074					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-15-81		23c. NAME OF CEMETERY OR CREMATORY Hampstead Cemetery		23d LOCATION CITY OR TOWN COUNTY STATE Hampstead Carroll Md.			
24 FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074				25. DATE REC'D. BY REGISTRAR AUG 18 1981 REGISTRAR'S SIGNATURE <u>James J. [Signature]</u>					

35
60
35
60
9
9
1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



[Faint, mostly illegible text, possibly bleed-through from the reverse side of the page. Some words like "MAY 1961" and "MAY 1961" are visible.]

AUG 18 1961

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 2 6 9	
FOR 1 - STATE REGISTRAR				REG. NO.	
1 DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Jane Muchmore Ricketts				2a DATE OF DEATH MONTH DAY YEAR August 20 1981	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 25 26	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New Jersey		7b CITIZEN OF WHAT COUNTRY? USA		8. AGE (IN YEARS, LAST BIRTHDAY) 55 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 YRS. HOURS MIN.	
10 CITY OR TOWN OF DEATH Finksburg		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2947 Bloom Road		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll Co. MD.	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Hwf				12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.				13b. COUNTY Carroll	
13c. CITY OR TOWN Finksburg				13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 2947 Bloom Road					
14 FATHER'S NAME FIRST MIDDLE LAST Boyd Muchmore		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Miriam Eckert			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 1147-22-8042		17 INFORMANT ADDRESS Mr. William W. Ricketts, Finksburg, Md.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1990 Carcinomatosis DUE TO, OR AS A CONSEQUENCE OF (b) 9 months Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from March 2, 1981, to August 20, 1981, that (I) (we) lost saw the deceased alive on August 13, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE C.E. McWilliams		22c. DATE SIGNED 8-21-81		22d. PHYSICIAN'S NAME (TYPE OR PRINT) C.E. McWilliams	
22e. ADDRESS 11904 Keisterton Rd, Keisterton Md. 21136					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-24-81		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mem. Gardens	
23d. LOCATION CITY OR TOWN Finksburg		23e. COUNTY Carroll		23f. STATE Md.	
24 FUNERAL DIRECTOR NAME Eline Funeral Home, Hampstead, Md. 21074		25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE AUG 26 1981			

2



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

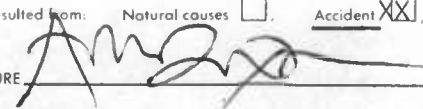

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DMMH-17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thelma M. Riddle			2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> MONTH DAY YEAR 8 20 19 81			2b. HOUR 6:10 P.M.		
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 30, 1931	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 49	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 8 20 19 81	7d. HOUR 6:10 P.M.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County		
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Rt. 140 & 91, southwest side			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maryland Cup Corp.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Balto.	13c. CITY OR TOWN Owings Mills	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 107 Enchanted Hills Road			
14. FATHER'S NAME FIRST MIDDLE LAST William Schaper				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Nelmeier				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215-28-2074		17. INFORMANT ADDRESS Mrs. Brenda L. Powers Balto. Md. 21206				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR MONTH DAY YEAR 5:09 P.M. 8 20 19 81		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) driver in auto/auto collision				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) highway		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Rt. 140 & 91, Westminster, Carroll Co., Md.				
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE 		TITLE (SPECIFY) Assistant			MEDICAL EXAMINER		DATE SIGNED 8-21-81	
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn Street						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Aug. 24, 81		23c. NAME OF CEMETERY OR CREMATORY Evergreen Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg, Md.		
24. FUNERAL DIRECTOR NAME ADDRESS Eline Funeral Home Reisterstown, Md. 21136				25a. DATE REC'D. BY REGISTRAR AUG 25 1981		25b. REGISTRAR'S SIGNATURE 		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 2 7 1

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELLA Augusta RIPLEY			2a. DATE OF DEATH MONTH DAY YEAR August 10, 1981		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 12, 1904		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 76 YRS. 10 28	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll Co., MD.	
10. CITY OR TOWN OF DEATH Sykesville	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1008 Circle Drive		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Carroll	13c. CITY OR TOWN Sykesville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Howard H. Leatherwood			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillie Gertrude Fowable		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-30-4513		17. INFORMANT ADDRESS Samuel B. Ripley, Same As #13	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerosis generalized, ASHD, 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) coronary artery disease, cardiac arrest, DUE TO, OR AS A CONSEQUENCE OF (c) hiatal hernia					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1954 , 19____, to 8-10-81 , 19____, that (I) (we) last saw the deceased alive on 8-10- 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Howard E. Hall		DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8-11-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard E. Hall, M.D., P.A.		22e. ADDRESS PO Box 318, Sykesville, Md. 21784			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-14-1981		23c. NAME OF CEMETERY OR CREMATORY Morgan Chapel	
23d. LOCATION CITY OR TOWN COUNTY STATE Carroll, Md.		23e. DATE REC'D. BY REGISTRAR AUG 14 1981			
24. FUNERAL DIRECTOR NAME ADDRESS Charles W. Burrier, Jr., Sykesville, Md.					

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DHMH - 16 50M 1/81
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

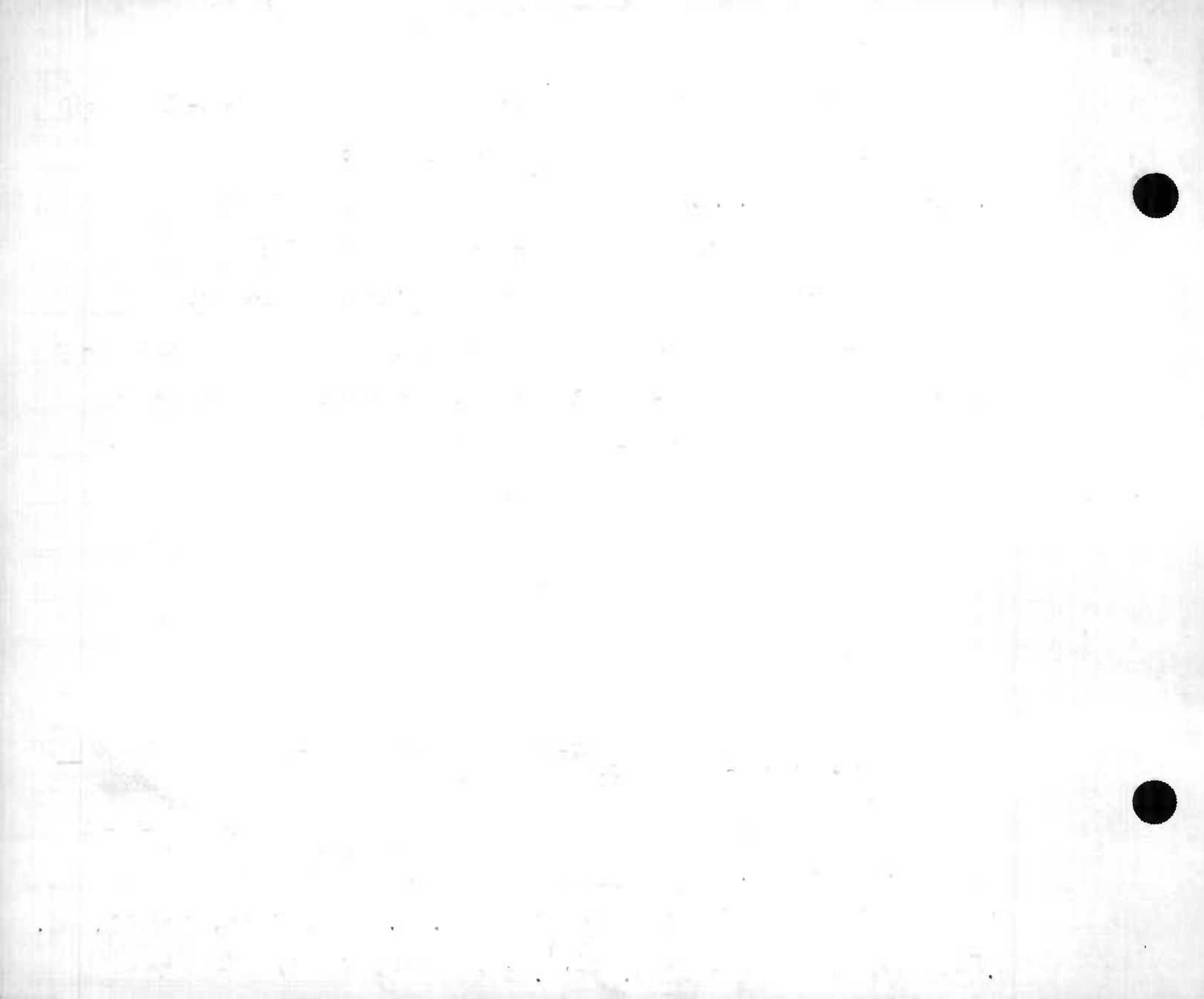
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) PAULINE H. SAYLOR					2a. DATE OF DEATH MONTH DAY YEAR AUG 30 1981				
3. SEX Female					7b. HOUR 12³⁰ PM				
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR Sept 2 1906			6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.			
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. GEN HOSP.			12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY None		
13a. STATE MD		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 54 Keswick Rd	
14. FATHER'S NAME FIRST MIDDLE LAST JOHN M. HOOK					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Julia Wagner				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 213-05-1259		17. INFORMANT ADDRESS S. Levine Saylor.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ACUTE MASSIVE MYOCARDIAL INFARCTION 4100 } DUE TO, OR AS A CONSEQUENCE OF (b) ISCHEMIC HEART DISEASE Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) 4 YEARS APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 HOUR.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from MAY 81 to AUGUST 30 81 , that (I) (we) lost saw the deceased alive on AUGUST 30 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Daniel I. Welliver MD DEGREE MD					22c. DATE SIGNED 8-30-81			22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER, MD	
22e. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD					22f. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MD				
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 9/2/81		23c. NAME OF CEMETERY OR CREMATORY Evergreen Mt.		23d. LOCATION CITY OR TOWN COUNTY Finksburg Carroll Md.			
24. FUNERAL DIRECTOR NAME Pratts Funeral Home, Westminster Md					25a. DATE REC'D BY REGISTRAR SEP 4 1981				
25b. REGISTRAR'S SIGNATURE James J. [Signature]									

TO HOSPITAL'S ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 1 2 7 3	
1. FOR STATE REGISTRAR			REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)			FIRST Thelma			MIDDLE Louise			LAST Sexton		
2. DATE OF DEATH			MONTH 08			DAY 10			YEAR 81		
2b. HOUR			P			2:50			M		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		
Female			White			MONTH 08 DAY 05 YEAR 18			63		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		
W. Virginia			U.S.A.						Carroll County MD.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville			Springfield Hospital Center			housewife					
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET ADDRESS		
Maryland			City			Baltimore			1346 Meridene Drive		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		
Henderson			Goss			No			214-30-6331		
17. INFORMANT			ADDRESS			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Right-sided pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH weeks		
Records, Springfield Hospital Center									years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22. I certify that (I) (this hospital) attended the deceased from <u>07-19</u> , 19 <u>77</u> , to <u>08-10</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>08-10</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Suhagun, M.D.</u>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 08-10-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Suhagun, M.D.			22e. ADDRESS Springfield Hospital Center Sykesville, Maryland 21784								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial			8/13/1981			Lake View Mem. Pk.			Sykesville, Carroll, Md.		
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE		
G. TROHAN			5151 Balto. Nat'l. Pike			AUG 14 1981					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

M1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 2 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Marie Gill Shipley			2a. DATE OF DEATH MONTH DAY YEAR 8 13 '81			2b. HOUR 11:35 P.M.				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 21 94		6. AGE (IN YEARS LAST BIRTHDAY) 87		7. IF UNDER 1 YEAR MONTHS DAYS 87		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Frederick County, Md.		7b. CITIZEN OF WHAT COUNTRY? Us.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll County, MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nazg + Genl. Cntr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY —		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md					13c. COUNTY Carroll		13d. CITY OR TOWN Westminster		13e. STREET ADDRESS 30 W. Green St.	
14. FATHER'S NAME FIRST MIDDLE LAST Wallace Shipley					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Horn					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-36-8141		17. INFORMANT ADDRESS Ralph Hoffman Court St. Westminster					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CVA 4292 DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 week 15/15								PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		
19a. DATE OF OPERATION 9-12			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR —		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET CITY OR TOWN COUNTY STATE —					
22a. I certify that (1) (this hospital) attended the deceased from 9-12 19 80 , to 8-13 19 81 , that (b) (we) lost saw the deceased alive on 8-12 19 81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (c) (we) (did not) view the body after death.										
22b. SIGNATURE Alva S. Baker MD					DEGREE —			22c. DATE SIGNED 8-14-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alva S. Baker					22e. ADDRESS 318 Washington Hgts Med Ctr Westminster MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 8-16-81		23c. NAME OF CEMETERY OR CREMATORY Linganore Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Frederick Maryland		
24. FUNERAL DIRECTOR NAME Fletcher Funeral Home					25. DATE PREPARED BY REGISTRAR OR REGISTRAR'S SIGNATURE AUG 17 1981					

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Handwritten notes and numbers, including "10", "15", "20", "25", "30", "35", "40", "45", "50", "55", "60", "65", "70", "75", "80", "85", "90", "95", "100".

Handwritten notes and numbers, including "10", "15", "20", "25", "30", "35", "40", "45", "50", "55", "60", "65", "70", "75", "80", "85", "90", "95", "100".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the director, page 3 should be filed in the office of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR			8 1 2 1 2 7 5 REG. NO.						
1 DECEASED NAME (TYPE OR PRINT) Charles Monroe Simpson			2a DATE OF DEATH MONTH DAY YEAR August 10, 1981				2b HOUR 3 A M		
3 SEX Male		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR Dec. 20 1905		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll County MD			
10 CITY OR TOWN OF DEATH Taneytown		11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4606 Ruggles Road				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shop worker		12b KIND OF BUSINESS OR INDUSTRY Railroad	
13a STATE Maryland		13b COUNTY Carroll		13c CITY OR TOWN Taneytown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 4606 Ruggles Road	
14 FATHER'S NAME FIRST MIDDLE LAST Charles F. Simpson				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Weishaar					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-12-2079		17 INFORMANT ADDRESS Mrs. Mary Simpson, 4606 Ruggles Road Taneytown, Md. 21787					
18 CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST 1991 DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:									
19a DATE OF OPERATION —		19b CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE					
22a I certify that (I) (this hospital) attended the deceased from 8/9/81 to present , that (I) (we) last saw the deceased alive on 8/9/81 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE John Lehigh		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c DATE SIGNED 8/10/81			
22d PHYSICIAN'S NAME (TYPE OR PRINT) JOHN LEHIGH		22e ADDRESS 104 N. MAIN ST. U MON BRIDGE, MD							
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Aug. 12, 1981		23c NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery		23d LOCATION New Windsor Westminister, Carroll Maryland			
24 FUNERAL DIRECTOR NAME Skiles Funeral Home		ADDRESS 136 E. Balto. Taneytown, Md		25 DATE REC'D. BY REGISTRAR AUG 11 1981		REGISTRAR'S SIGNATURE James J. [Signature]			

4

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8121276

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) ELIZABETH H. Stoner			2a. DATE OF DEATH MONTH 8 - DAY 31 - YEAR 81		2b. HOUR 8:30 P.M.
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH 7 DAY 03 YEAR 03		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS	IF UNDER 1 YEAR MONTHS 0 DAYS 0 IF UNDER 24 HRS HOURS 0 MIN. 0
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Scotland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.	
10. CITY OR TOWN OF DEATH Westminster	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WNCB		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Carroll 13c. CITY OR TOWN Westminster			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 152 Willis St.
14. FATHER'S NAME FIRST JAMES MIDDLE Hay LAST Stoner			15. MOTHER'S MAIDEN NAME FIRST MARY MIDDLE Mc LAST Shes		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 212-09-4357		17. INFORMANT Dan. Stoner ADDRESS Westminster, Md	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Ruptured Abdominal Aneurysm 4413 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (d): Chronic Osteoarthritis Pulmonary Disease					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from 8/26/81 to 8/31/81 , that (I) (we) lost above, (I) (we) (did) (did not) view the body after death, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated.					
22b. SIGNATURE Richard D. Thompson M.D.				22c. DATE SIGNED 8/31/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD D. THOMPSON				22e. ADDRESS Suite 12 Carroll Plaza, Westminster Md	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-3-81		23c. NAME OF CEMETERY OR CREMATORY KRIDERS	
23d. LOCATION CITY OR TOWN COUNTY STATE Westminster Carroll Md		23e. DATE REC'D. BY REGISTRAR SEP 3 1981		23f. REGISTRAR'S SIGNATURE James J. [Signature]	
24. FUNERAL DIRECTOR Robert Kyle Priths Jr. ADDRESS Westminster, Md					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
OFFICE OF THE
DIRECTOR
JAN 11 1911

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 10th inst. in relation to the matter of the proposed amendment to the charter of the City of New York, and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Your obedient servant,
J. J. [Signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrars, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 2 7 7

1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ARTHUR C. TAYLOR		2a. DATE OF DEATH MONTH DAY YEAR 8 7 81	
3. SEX MALE		2b. HOUR 2058 M	
4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 12 07	
6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA	
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL CO. GEN HSP	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABOR		12b. KIND OF BUSINESS OR INDUSTRY Koppers Pt.	
13a. STATE MD		13b. COUNTY CARROLL	
13c. CITY OR TOWN Westminster		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET ADDRESS 606 W. WESTMINSTER AVE			
14. FATHER'S NAME FIRST MIDDLE LAST ERWIN TAYLOR		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARGARET NESS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO 213-05-1493	
17. INFORMANT ARTHUR TAYLOR		ADDRESS Green St.	
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAC ARREST 4100 DUE TO, OR AS A CONSEQUENCE OF (b) LEFT VENTRICULAR DYSFUNCTION DUE TO, OR AS A CONSEQUENCE OF (c) MYOCARDIAL INFARCTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMED. 1 MO. 1 MO.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. DIABETES MELLITUS			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 7/2 19 81 , to 8/7 19 81 , that (I) (we) lost saw the deceased alive on 8/6 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Theresa J. Pious		DEGREE MD	
22c. DATE SIGNED 8/7/81		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Theresa J. Pious		22e. ADDRESS Westminster	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/11/81	
23c. NAME OF CEMETERY OR CREMATORY Wesley		23d. LOCATION CITY OR TOWN COUNTY Westminster Carroll	
24. FUNERAL DIRECTOR Fritz Turner		25a. DATE REC'D. BY REGISTRAR AUG 14 1981	
25b. REGISTRAR'S SIGNATURE Theresa J. Pious			

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(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1 - FOR STATE REGISTRAR		Mabel B. Tolbert							
1 DECEASED NAME (TYPE OR PRINT)		FIRST Mabel		MIDDLE B.		LAST Tolbert		2a. DATE OF DEATH MONTH DAY YEAR 08 26 81	
3 SEX Female		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR 12 13 92		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		2b. HOUR 0843 M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S.C.		7b. CITIZEN OF WHAT COUNTRY? US		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.			
10 CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Carroll Co Gen'l Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Home	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE MD		13b. COUNTY Carroll		13c. CITY OR TOWN Sykesville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4202 7200 Third Avenue	
14. FATHER'S NAME FIRST E. MIDDLE J. LAST Brown		15. MOTHER'S MAIDEN NAME FIRST Fannie MIDDLE McNairy							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 578-52-6842		17 INFORMANT ADDRESS Wash., D.C. Betty Lou Tolbert 3931 Langley Ct. N.W.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4029 Cardiac arrest								~45 min	
DUE TO, OR AS A CONSEQUENCE OF (b) CHF								~1 hour	
DUE TO, OR AS A CONSEQUENCE OF (c) HASCVD								~5 yrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: gastrointestinal bleeding									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NO WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 7-28, 19 81, to 8-26, 19 81, that (2) we last saw the deceased alive on 8-21, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death, so state.)									
22b. SIGNATURE Olga M. Baker M.D.				DEGREE				22c. DATE SIGNED 8-26-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Hvg S. Baker M.D.				22e. ADDRESS 218 Washington Heights Med Ctr Westminister MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/31/81		23c. NAME OF CEMETERY OR CREMATORY Nat'l. Mem. Park		23d. LOCATION CITY OR TOWN COUNTY STATE Falls Church, Va.			
24. FUNERAL DIRECTOR Joseph Gawler's Sons, Inc. NAME 5130 Wisc. Ave. N.W. Wash., D.C.				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 01 1981 Frances Jean Wether					



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

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FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Wava Catharine Weller			2a. DATE OF DEATH MONTH DAY YEAR 8 21 81			2b. HOUR 8:30 P.M.		
3. SEX Female		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 9 27 05		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.		
10. CITY OR TOWN OF DEATH Carroll		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT HOSPITAL, GIVE STREET ADDRESS) Westminster Nursing and WNCC Convalescent Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		
12b. KIND OF BUSINESS OR INDUSTRY own home								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD				13b. COUNTY Carroll		13c. CITY OR TOWN Union Bridge		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 4 S. Main St. MD-21791				
14. FATHER'S NAME FIRST MIDDLE LAST Glenn Lightner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rhoda Snyder				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No none				16b. SOCIAL SECURITY NO. 213-03-1073		17. INFORMANT ADDRESS N. Main St. John S. Lightner Union Bridge, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CVA 4292 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 3a. 3b. 3c.								
MEDICAL CERTIFICATION								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) (this hospital) attended the deceased from 1-28-80 to 8-21-81, that (1) (we) lost saw the deceased alive on 8-20-81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death.								
22b. SIGNATURE Alma S. Baker				DEGREE		22c. DATE SIGNED 8-28-81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alma S. Baker				22e. ADDRESS 218 Washington Heights Med Ctr Westminster, MD 21157				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8/25/81		23c. NAME OF CEMETERY OR CREMATORY Pipe Creek Cemetery		23d. LOCATION near TOWN COUNTY STATE New Windsor Carroll Md.		
24. FUNERAL DIRECTOR NAME D. D. Darter				ADDRESS Union Bridge, Md.		25a. DATE REC'D. BY REGISTRAR AUG 25 1981		
				25b. REGISTRAR'S SIGNATURE Rome Jean Porter				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the County after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 2681, 2682, 2683, 2684, 2685, 2686, 26

8-2-01

1852

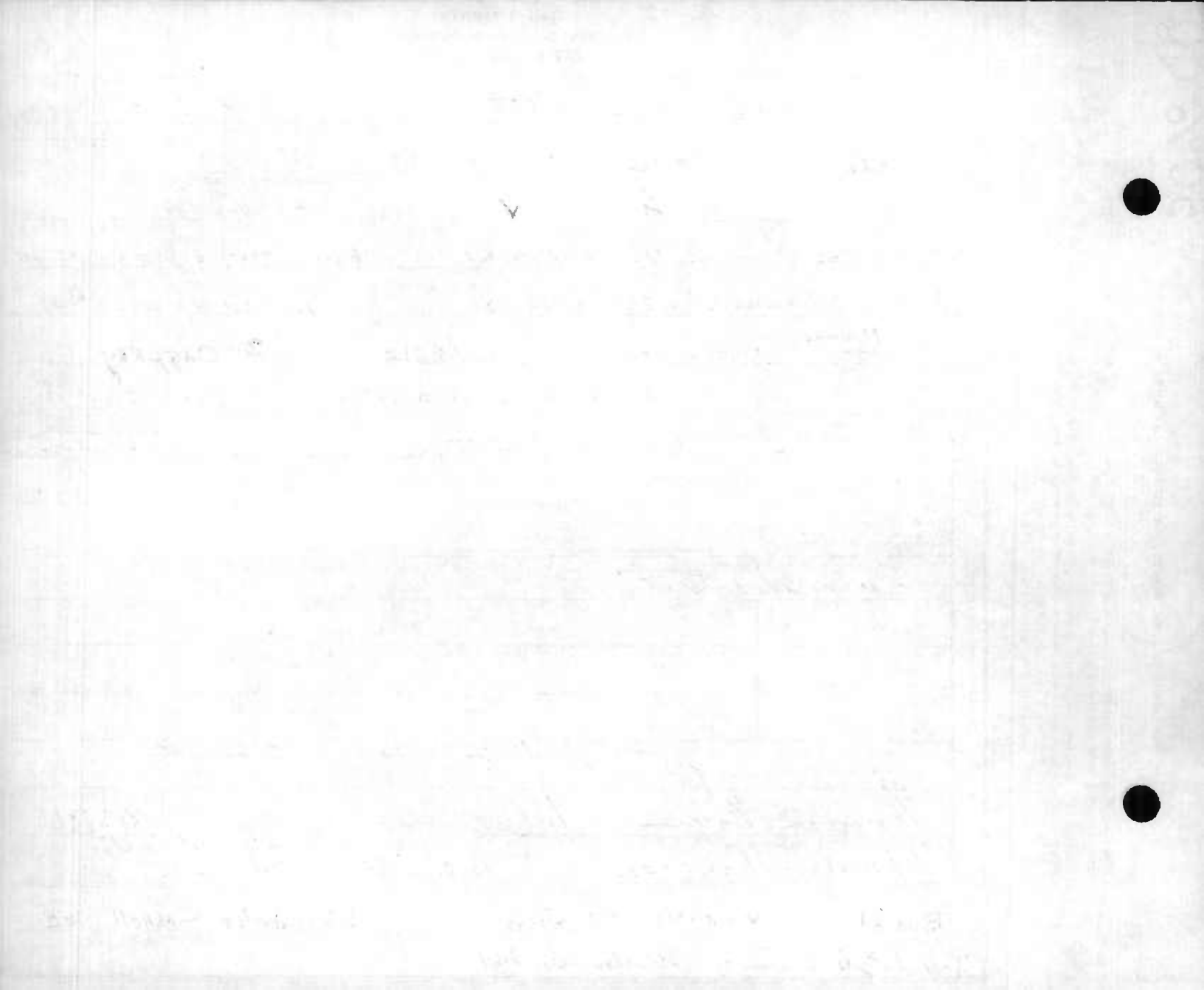
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8121280	
1- FOR STATE REGISTRAR										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPHINE DOYLE WEST						2a. DATE OF DEATH MONTH DAY YEAR 8 5 81		2b. HOUR 10:40 PM			
3. SEX Female		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 2 19 1910		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 71 YRS.		IF UNDER 1 YEAR IF UNDER 24 HRS.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL Co. MD.					
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4 OLD NEW WINDSOR RD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) ADMINISTRATIVE		12b. KIND OF BUSINESS OR INDUSTRY EDUCATION			
13a. STATE MD		13b. COUNTY CARROLL		13c. CITY OR TOWN WESTMINSTER		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4 OLD NEW WINDSOR RD.			
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW ANDREW DOYLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CARRIE MCCASPERY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 21622 8430		17. INFORMANT RICHARD WEST		ADDRESS 4 OLD NEW WINDSOR RD. WESTMINSTER, MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CARDIAL ARREST										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 min	
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS										2 days	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Sepsis											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from Aug , 19 70 , to 8/5 , 19 81 , that (I) (we) last saw the deceased alive on 8/5 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Norman Poulson		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/5/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN POULSEN				22e. ADDRESS 218 Wash Hts Med Center Westminster, Md. 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 8-8-81		23c. NAME OF CEMETERY OR CREMATORY St. Johns		23d. LOCATION CITY OR TOWN COUNTY STATE Westminster CARROLL MD					
24. FUNERAL DIRECTOR NAME Robert H. Puth R.				ADDRESS Westminster, Md		25a. DATE RECD. BY REGISTRAR AUG 12 1981		25b. REGISTRAR'S SIGNATURE Norman Poulson			



BP

DHMH - 16 50M 7/77
(VR A 15 (4))

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 1 2 1 2 8 1			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EDITA ELIZABETH WUEST				2a. DATE OF DEATH MONTH DAY YEAR AUG 18 1981		2b. HOUR 4 PM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAY 2 1903		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? UNITED STATES		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.	
10. CITY OR TOWN OF DEATH WESTMINSTER		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 379 N. COLONIAL AVE		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK		12b. KIND OF BUSINESS OR INDUSTRY AGG - U.S.G.V	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY 13d. INSIDE CITY LIMITS? MARYLAND CARROLL WESTMINSTER YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e. STREET ADDRESS 379 N. COLONIAL AVE WESTMINSTER MD			
14. FATHER'S NAME FIRST MIDDLE LAST HENRY LITTLE				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNIE HOFFMAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-07-2800		17. INFORMANT Wilis H. Rickert Jr		ADDRESS 6704 Carlinda Ave Columbia Md 21046	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) ACUTE CARDIAC ARREST 4292 DUE TO, OR AS A CONSEQUENCE OF (b) A.S.C.V.D. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 YEARS							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR SEPT 6 1981		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from AUG 18 1981 to AUG 18 1981 , that I (we) last saw the deceased alive on AUG 18 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE Daniel I. Welliver MD.				DEGREE MD.		22c. DATE SIGNED 8-18-81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL I. WELLIVER				22e. ADDRESS 218 WASHINGTON HEIGHTS WESTMINSTER MARYLAND			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 8-21-81		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION CITY OR TOWN COUNTY STATE Finksburg Carroll Md	
24. FUNERAL DIRECTOR NAME Robert L. Prith Jr.				ADDRESS Westminster, Md		25a. DATE REC'D. BY REGISTRAR AUG 24 1981	
				25b. REGISTRAR'S SIGNATURE Shirley G. Hart			



FOOT & CLERK - WEST

FEMALE - WHITE - 1872

MADE AND BORN IN THE

WESTERN STATE OF NEW YORK

AND WAS BORN

January 27th 1872

TO HER MOTHER MRS. R. K. K. K.

FOOT & CLERK - WEST

MADE AND BORN IN THE

WESTERN STATE OF NEW YORK

1872

MADE AND BORN IN THE



FOOT & CLERK - WEST

MADE AND BORN IN THE

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 2 8 2

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Sallie K. John			2a. DATE OF DEATH MONTH DAY YEAR 8/30/81			2b. HOUR M				
3 SEX F		4 RACE W		5. DATE OF BIRTH MONTH DAY YEAR 11 11 61		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS.		7. UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.				
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Hsg. Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SEAMSTRESS		12b. KIND OF BUSINESS OR INDUSTRY sewing, fabric		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md					13b. CITY OR TOWN CARROLL		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 56 BOND ST.	
14. FATHER'S NAME FIRST MIDDLE LAST Samuel Ruckson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Linda Rucker							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 220-16-3285		17. INFORMANT ADDRESS Phyllis Shattuck Wankesky Wis					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Renal disease 5829 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 mos		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION 9/30/80			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Kidney Calculus			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital) attended the deceased from 5/10, 1977, to 8/30, 1981, that (1) we lost saw the deceased alive on 8/12, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death.										
22b. SIGNATURE Julius Chepko			DEGREE M.D.			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/30/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Julius Chepko			22e. ADDRESS 8512 W. Green St Westminster, Md 21157							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/2/81		23c. NAME OF CEMETERY OR CREMATORY Meadow Brook		23d. LOCATION CITY OR TOWN COUNTY Westminster Carroll Md			
24. FUNERAL DIRECTOR NAME Pinto's Funeral Home			ADDRESS Westminster, Md		25a. DATE REC'D. BY REGISTRAR SEP 4 1981		25b. REGISTRAR'S SIGNATURE [Signature]			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 1 2 1 2 8 3

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS Andrew Young			2a. DATE OF DEATH MONTH DAY YEAR 8/1/81			2b. HOUR 1:15 PM M				
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH MONTH DAY YEAR 4 12 11		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS		7. IF UNDER 1 YEAR MONTHS DAYS 3 25		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? USA		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.				
12. CITY OR TOWN OF DEATH Westminster		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Westminster Nursing Center				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		15. KIND OF BUSINESS OR INDUSTRY Landscaping		
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 16a. STATE MD.			16b. COUNTY Carroll		16c. CITY OR TOWN Westminster		16d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		16e. STREET ADDRESS 2221 Liberty Road	
17. FATHER'S NAME FIRST MIDDLE LAST George C. Young			18. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Pearl M. Barnes			19. ADDRESS 1224 Damsel Rd. Virginia B. Maule, Baltimore, Md.				
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			21. SOCIAL SECURITY NO. 218-09-1831			22. INFORMANT Virginia B. Maule, Baltimore, Md.				
23. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma, prostate</u> 1850 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 yrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) CORD										
24. DATE OF OPERATION 7-28-81			25. CONDITION FOR WHICH OPERATION WAS PERFORMED Ca prostate			26. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
31. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			32. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			33. LOCATION STREET CITY OR TOWN COUNTY STATE				
34. I certify that (I) (this hospital) attended the deceased from 7-15 1981 to 8-7 1981, that (we) last saw the deceased alive on 8-6 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.										
35. SIGNATURE Alva S. Baker M.D.			36. DEGREE			37. MEDICAL ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		38. DATE SIGNED 8-7-81		
39. PHYSICIAN'S NAME (TYPE OR PRINT) Alva S. Baker M.D.			40. ADDRESS 218 Washington Heights Med Ctr Westminster MD 21157							
41. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			42. DATE 8-11-1981		43. NAME OF CEMETERY OR CREMATORY Taylorsville		44. LOCATION CITY OR TOWN COUNTY STATE Taylorsville, Carroll, Md.			
45. FUNERAL DIRECTOR NAME Charles W. Burrier, Jr., Sykesville, Md.						46. DATE REC'D. BY REGISTRAR AUG 11 1981		47. REGISTRAR'S SIGNATURE		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8	1	2	1	2	3	4	
1. FOR STATE REGISTRAR										REG. NO.							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Dorothy Helen ZARTA										2a. DATE OF DEATH MONTH DAY YEAR 8/11/81				2b. HOUR 10⁰⁵			
3. SEX Female			4. RACE White			5. DATE OF BIRTH MONTH DAY YEAR May 17, 1921				6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.			7. UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Massachusetts			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Carroll MD.							
10. CITY OR TOWN OF DEATH Mt. Airy			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 216 Oak Street							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE Maryland										13b. COUNTY Carroll		13c. CITY OR TOWN Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 216 Oak Street	
14. FATHER'S NAME FIRST MIDDLE LAST William Dumas					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Driscoll												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 021-16-7069			17. INFORMANT William J. Zarta				ADDRESS Item 13							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b): central nervous tumor DUE TO, OR AS A CONSEQUENCE OF (c): small cell ca lung Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30 d 18 mo							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from Mar , 19 81 , to 8/11 , 19 81 , that (I) (we) lost saw the deceased alive on 8/9 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE [Signature] DEGREE										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/11/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) P. G. T. Rousch						22e. ADDRESS 4 West Seventh Frey											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8/13/81		23c. NAME OF CEMETERY OR CREMATORY Pine Grove				23d. LOCATION CITY OR TOWN COUNTY STATE Mt. Airy Carroll Md.							
24. FUNERAL DIRECTOR NAME Olin L. Molesworth, P.A., Damascus, Md.						25a. DATE REC'D. BY REGISTRAR AUG 13 1981		25b. REGISTRAR'S SIGNATURE [Signature]									

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

21285

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		26. DATE KNOWN OF DEATH		ESTI- MATED		MONTH		DAY		YEAR		27b. HOUR	
Joseph Eiton Zentgraf								8		1		81						A.M.	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		27c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		27d. HOUR	
MALE	WHITE	2 23 1913		68		MONTHS		DAYS		8		1		81				A.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Md		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		CARROLL													
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Westminster		CARROLL County General		ELECTRICIAN		Rail Road													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md		CARROLL		CARROLLTON		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		511 Dutaow Rd											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
John Joseph Zentgraf		Alveta V. Dull																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
NO		NONE		70514 0345		SARAH M. Zentgraf		21025											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
4292		Atherosclerotic Cardiovascular Disease																	
Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause lost.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?															
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
		P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/>																	
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED															
Examiner's Name (TYPE OR PRINT)		ADDRESS																	
Burial		8-5-81		Pleasant Valley		Westminster		CARROLL		Md									
24. FUNERAL DIRECTOR		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE									
Robert E. Poth, Jr.																			
25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) WALTER E ZEPPE			2a. DATE OF DEATH MONTH 8 DAY 26 YEAR 81			2b. HOUR 18:37 P. M.					
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 1 YEAR 23		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		7. IF UNDER 24 HRS HOURS 0 MIN. 0	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CARROLL MD.					
10. CITY OR TOWN OF DEATH Westminster		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CARROLL County Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Meat Cutter		12b. KIND OF BUSINESS OR INDUSTRY Meat			
13a. STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Randallstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13e. STREET ADDRESS 3201 offutt Rd.				14. FATHER'S NAME FIRST George MIDDLE Zeppe LAST Zeppe				15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Brothers LAST Brothers			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 218140211		17. INFORMANT ADDRESS Adelaide Zepp Randallstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Aug. 25, 1981 , to Aug 26, 1981 , that (I) (we) last saw the deceased alive on Aug 26, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arthur L Rudo, MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 8/26/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ARTHUR L RUDO, MD						22e. ADDRESS 524-B BALTIMORE BLVD WESTMINSTER MD 21157					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8-29-81		23c. NAME OF CEMETERY OR CREMATORY Wards Chapel Cemetery		23d. LOCATION CITY OR TOWN Randallstown COUNTY Balto. STATE Md.			
24. FUNERAL DIRECTOR NAME Harry W. Knight				ADDRESS Lysbeth, Md.		25a. DATE REC'D. BY REGISTRAR AUG 28 1981		25b. REGISTRAR'S SIGNATURE James Van Vorst			

TO HOSPITAL CONTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

BP

